DEC 17 1937

DECEMBER, 1937

HOSPITAL Management

A product of advanced research and manufacturing methods, scientifically processed to meet the most exacting standards for sterility, absorption, pliability, and tensile strength.

FOR THE SURGEON'S
TECHNIQUE . . . THE
PATIENT'S RECOVERY

LEWIS MANUFACTURING CO., *Division of* THE KENDALL COMPANY, *Walpole, Mass.*

HOSPITAL MANAGEMENT

CONTENTS THIS ISSUE

FEATURES

Christmas in the Hospital 14
By T. R. Ponton, M.D.

Personnel Management in the Hospital 18
By Frank J. Walter

Hospital Employes and the Workmen's Compensation Act 21
By I. H. Rubenstein

Fire Protection in Hospitals 22
By E. Ray Gram

DEPARTMENTS

To Talk of Many Things 8
In the Supplier's Library 10
As the Editors See It 12
In the News 26
Dietary and Food Service 31
Department of Nursing Service 39
Medical Records Department 49
Anesthesia — Pathology — X-Ray 52
The Hospital Housekeeper 55
New Products and Appliances 58
Index to Volume 44—June to December, 1937 60
Classified Advertisements 63
Index to Advertisements 64
How's Business? 65

VOL. 44—No. 6 : : : : DECEMBER, 1937

T. R. PONTON, B.A., M.D., Editor — MARSHALL REINIG, Publisher

A. B. ENGELSMAN, Assistant Editor

F. B. SHONDELL, Advertising Manager
MACDONALD BACON, Eastern Manager
8 West 40th Street, New York
Chickering 4-3311

E. BOSSERT, Circulation Manager
DON HARWAY & COMPANY
155 Montgomery St., San Francisco
318 W. Ninth St, Los Angeles

INSTITUTIONAL PUBLICATIONS INC.

HOSPITAL MANAGEMENT is published on the tenth of each month at 612 No. Michigan Avenue, Chicago, Illinois, by Institutional Publications, Inc. It is a member of the Audit Bureau of Circulations, and a member of the Associated Business Papers, Inc. Subscription, $2 a year. Single copies, 20 cents. in U. S.; Canada, $2.50 a year; foreign, $2.50 Entered as second class matter May 14, 1917, at the post office, Chicago, Illinois, under the act of March 3, 1879. Additional entry, St. Joseph, Mich.

WHY BUY BLIND?

• Peas under the nut-shell or food service equipment . . . it's all the same . . . in the long run what you get depends on the integrity of the seller. For you MUST have confidence that things below the surface are what they seem.

• You can depend on the members of the Food Service Equipment Industry, Inc., o· reliable, intelligent and prompt counsel and service. They are the well-established firms of the industry with a reputation to protect . . . they carry stocks, extend credit, employ salesmen . . . they are pledged to deliver merchandise, materials and workmanship exactly as specified. It will pay you in time, money and satisfaction to deal only with these firms that merit your complete confidence.

FOOD SERVICE EQUIPMENT INDUSTRY, INC.
2151 WEST PERSHING ROAD, CHICAGO, ILL.

MEMBER FIRMS

E. B. Adams Company
Washington, D. C.

Arkay Company
New York, N. Y.

Atlantic Restaurant Equip. Corp.
New York, N. Y.

Barth Equipment Co.
New York, N. Y.

Base and Base
New York, N. Y.

S. Blickman, Inc.
Weehawken, N. J.

Bramhall, Deane Co.
New York, N. Y.

Burton Range Co.
Cincinnati, Ohio

A. L. Cahn & Sons
New York, N. Y.

Carson Crockery Co.
Denver, Colorado

Victor V. Clad Co.
Philadelphia, Pa.

James F. Collins & Co.
Newark, N. J.

Combined Kitchen & Rest. Equip. Co.
Newark, N. J.

Cooke-Stubinger Hotel Kitchen Equipment Co.
St. Louis, Mo.

Cook's Hotel Rest. Sup. Company
New York, N. Y.

F. A. Davis & Sons,
Baltimore, Md.

Dommier & Schenck Co.
Pittsburgh, Pa.

Harry F. Dobbs, Inc.
Atlanta, Georgia

Dohrmann Hotel Sup. Co.
San Francisco, Cal.

W. F. Dougherty & Sons Co., Inc.
Philadelphia, Pa.

Duke Manufacturing Co.
St. Louis, Mo.

Duparquet, Huot & Moneuse Co.
Boston, Mass.

Duparquet Range Co.
Chicago, Ill.

Ezekiel & Weilman Company, Inc.
Richmond, Virginia

Fargo Food and Equip. Company
Fargo, N. D.

Ford Hotel Supply Co.
St. Louis, Mo.

H. Friedman & Sons, Inc.
New York, N. Y.

General Hotel Supply Co.
San Antonio, Tex.

Bernard Glockler Co.
Pittsburgh, Pa.

Morris Gordon & Son, Inc.
Boston, Mass.

Greene-Winkler Co.
Seattle, Wash.

Ideal Restaurant Sup. Co.
New York, N. Y.

Alex Janows & Co.
Chicago, Ill.

Joesting & Schilling Co.
St. Paul, Minn.

Sol Kramer & Co., Inc.
New York, N. Y.

Lenox, Inc.,
Boston, Mass.

S. M. Levin Co. Inc.,
Boston, Mass.

Loubat Glassware & Cork Co., Ltd.
New Orleans, La.

R. B. Martin, Inc.
New York, N. Y.

Mound City China Co.
St. Louis, Mo.

Murphy Hotel Supply Co.
St. Louis, Mo.

Natural Products Co.,
Boston, Mass.

Omaha Fixture & Sup. Company
Omaha, Neb.

Albert Pick Co., Inc.
Chicago, Ill.

P. B. Polhemus Co.
Roselle, N. J.

Russell & Watson, Inc.
Buffalo, N. Y.

Schoinick, Inc.
Pittsburgh, Pa.

Sam Schuham & Co.
Chicago, Ill.

Southern Equipment Co.
St. Louis, Mo.

Southern Hotel & Rest. Supplies, Inc.
St. Louis, Mo.

Star Metal Mfg. Co.
Philadelphia, Pa.

The Stearnes Co.
Chicago, Ill.

Nathan Straus-Duparquet, Inc.
New York, N. Y.

Swain & Myers, Inc.
Decatur, Illinois

Thompson-Winchester Company
Boston, Mass.

Traub-Estabrooke Co.
Chicago, Ill.

John Van Range Co.
Cincinnati, Ohio

E. L. Weiscopt
Boston, Mass.

The Winberg Company
Chicago, Ill.

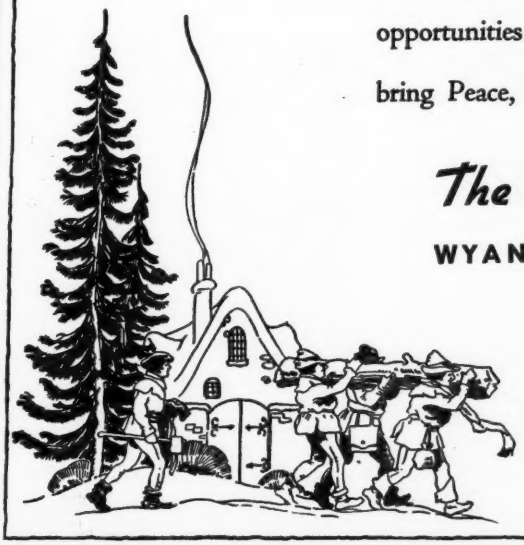
Wrought Iron Hotel Supply Co.
Denver, Colo.

Greetings

Merry Christmas!
Happy New Year!

What a happy arrangement, to have Christmas just before New Year's Day! Christmas is the time to "square accounts" for the year so nearly gone. Disappointments and discouragements are swept away by the flood tide of Good Cheer at Christmas. It brings new Hope and Confidence for the New Year.

This festival of Good-Will gives us occasion to express gratitude for countless friendships, and for the many opportunities given us to serve. May the New Year bring Peace, Happiness and Abundance to all!



The J. L. Ford Company

WYANDOTTE • MICHIGAN

Wyandotte PRODUCTS

"To Talk of Many Things . . . ."

Have a Heart

Recently I had occasion to be a patient in a hospital of 400 beds, and I don't suppose any person could have been in a less receptive mood.

First of all, I had tried to use my acquaintance with the superintendent to be allowed to enter late in the evening, but was refused. So I went in at the customary hour, one Sunday evening, and soon realized that the superintendent's refusal to grant me special privileges had saved me a day's stay.

First contact was, of course, with the admitting office. Here I was met by a very pleasant gentleman of mature years, and I use the word gentleman deliberately. Two things struck me very forcibly: First, while the admitting officer was writing the necessary admission data, he picked up the phone and advised the floor that I would be up in a few minutes. Second, just before he was ready to send me on, he pressed a button and presently a bell boy, in a smart uniform, appeared ready to show me to my room. No first class hotel could have shown more courteous efficiency.

As an example of the absolute thought for the comfort of the patient, let me say a little about the dietary arrangements.

During the course of the morning an assistant dietitian called on me and with her came several surprises. The first was the really selective menu. There was enough variety in items to allow a selection that would satisfy any taste. The second surprise came when I remarked that I was accustomed to a very light lunch and hated the early supper which is customary in the hospital. With a very pleasant smile the dietitian replied, "That is easy We will just switch the entree from noon to night, and what time do you like lunch and dinner?" Being curious, I asked some questions and found that the kitchen is never closed, so that patients can have meals when they want them instead of at the convenience of the chef and his staff. Even ward patients are not disturbed at unholy hours.

Noise is another factor about which we often hear complaints. Here was an old building, not soundproofed, yet I could go to sleep at any time. Several times when I woke from a nap, I found that a nurse or an orderly had been in. Why the lack of noise? No loud voices were to be heard, all were soft but clear; all carts and similar vehicles were rubber tired; most important of all, no person made careless noises. The net result was quiet in a very busy hospital.

I could ramble on indefinitely telling about the pleasantness of the resident staff, the brightness and efficiency of the nurses, the carefulness of the various attendants in the special departments, the smile and the sense of humor that was apparent everywhere, the visit of the librarian to see whether I wanted books and many other courtesies, but space forbids.

Your natural reaction is that all this costs money. It does not. The cost of operating this hospital is no greater than that of comparable institutions and it is less than many. When I got my account I checked it over carefully and none of the charges were above average; some were below. To this must be added that as another worker in the hospital field I received a liberal discount.

I thought I knew how to run a hospital, but I take off my hat to Asa Bacon of the Presbyterian.

Impetigo Again

I have recently had an S.O.S. from a hospital which is having a desperate, and not too successful, fight against recurring cases of impetigo. The writer speaks of painting and sterilizing and is contemplating fumigating. Judging from my own hospital experience with the disease, all this is unnecessary. The nursery is always clean and the infant clothes as they come from the laundry are sterile.

The big problem is prevention of contact infection. The writer speaks of the prevalence of impetigo in the schools and, I have found that, when this prevalence exists there is a constant fight to prevent the infection being carried to the infant.

Of course all modern hospitals prevent direct contact with the babies, but how often do we overlook the indirect contact through the mother. A contaminated visitor sits on the bed, handles the bed clothes or otherwise leaves the bacteria around the mother. Then the baby comes in to nurse and becomes infected.

Space forbids entering into any lengthy discussion of treatment but I wish to call attention to one fact regarding the use of the ultra violet ray. It has a very slight penetration, therefore the surface must be absolutely free from oil or other extraneous material which would prevent the ray penetrating to the site of infection. For the same reason the covering of the bleb must also be wiped away, paying particular attention to the shelving edge under which the infection lurks.

I have not attempted, in the above, to enter into a complete discussion of the subject, but rather have tried to suggest a few of the lines of thought which have led to a successful fight against the disease.

Controlling The Flow Of Oxygen

When visiting hospitals in the various parts of the United States and Canada, I have often noticed the wastefulness and inadequacy of the means used to control the flow of oxygen. So many hospital administrators hesitate to spend the amount necessary for special valves and attempt to control the rate of flow through the coarse valve belonging to the tank, measuring the flow by the water bubbles. This is such a penny wise and pound foolish policy that I am surprised at its persistence. The wastage of oxygen is enormous and a proper needle valve attachment, which costs less than $50.00, would soon be paid for by the saving in gas.

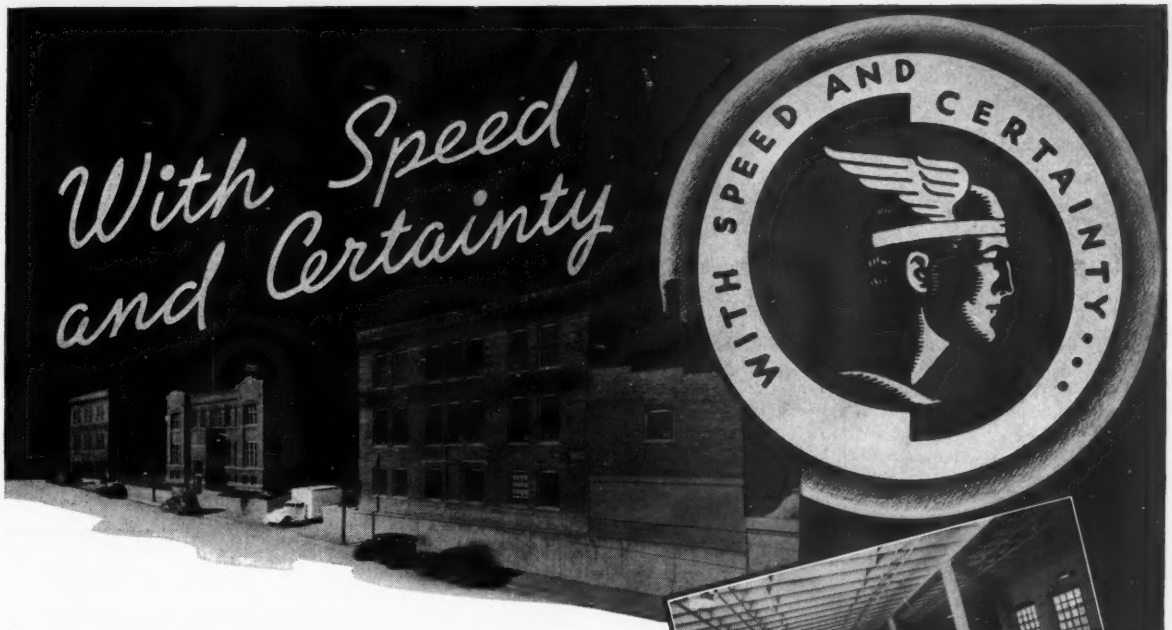
But the worst feature of the lack of proper control is that the patient is not getting oxygen therapy. The essential point of this method of treatment is that a measured quantity of oxygen is administered evenly and over long periods without interruption.

To those hospitals who are trying to administer oxygen without the necessary apparatus, I say stop the camouflage. Don't be lulled into a false sense of security because you have a tank of oxygen. The real problem is to get the gas to the patient. You may not be able to afford an oxygen tent or an oxygen room, but a nasal catheter costs little, and the funnel helps some in cases not suitable for the catheter. In any case a reducing valve and gauge are absolutely essential in any method of administration.

A happy Christmas and a very prosperous New Year to all coworkers in the hospital field.

J. A. Ponton

With Speed and Certainty



THE Will Ross trade-mark is founded on actually *doing* what it *signifies.*

Meeting the physical needs of hospitals with *speed* and *certainty* is a vital factor in insuring prompt, unerring care of the sick *in* the hospitals.

To do full justice to its function as a dependable source for hospital necessities, a supply house must maintain *complete and adequate stocks of everything that might be needed by the hospital at any time* . . . and the Will Ross Catalog lists more than 6,000 such items.

To maintain such complete and adequate stocks, an adequate physical set-up is necessary. Will Ross floor space permits highly systematized, orderly arrangement of all merchandise...every item under *perpetual inventory control* which provides protection against stock depletion.

And in the final analysis, to take full advantage of adequate stocks and an adequate physical set-up, an ideal-conscious, thoroughly trained and experienced personnel in all departments is vital—from the order desk to the shipping desk.

It is because the Will Ross Organization operates on this plan that all orders go forward with *Speed* and *Certainty.*

WILL ROSS, Inc. 3100 W. CENTER ST. MILWAUKEE, WIS.

WHOLESALE HOSPITAL SUPPLIES

IN THE SUPPLIERS' LIBRARY

Request to Hospital Management will bring these new folders and latest information about equipment and supplies. Ask for them by numbers for convenience.

No. 498. New broadside has been released by Troy Laundry Machinery Division of American Machine and Metals, Inc. on the firm's new line of Atlas **washing machines.**

No. 497. **"The Drama of Modern Surgery"**—a set of professionally-posed photographs, illustrating important aspects of surgical technic. Lewis Manufacturing Co.

No. 496. **"Plaster Casts—Their Preparation in the Hospital"** is a 74-page illustrated textbook covering the hospital handling of crinoline and plaster. Lewis Manufacturing Co.

No. 495. **"Chemical and Biological Laboratory Instruments"**, Catalog No. 38HM, is announced by the American Instrument Company. It presents information on the latest developments in the firm's scientific instruments.

No. 494. **"How to Feed Young Children in the Home"** is the title of a new book on child feeding which is being distributed by the Irradiated Evaporated Milk Institute.

No. 493. American District Steam Company has released a bulletin which illustrates and describes the use of fibrous glass for the **insulation of underground steam lines.** The insulation is trade-named ADSCO-Corning Filler Insulation.

No. 492. Reynolds Electric Company has issued a new bulletin (No. 618) on its line of **heavy duty food mixers.**

No. 491. A 16-page catalog, published by the Elgin Softener Corporation, covers the subject of **water conditioning** and Elgin Zeolite water softeners. It also includes information on Elgin Elconite softeners for providing iron-free water, oil removal filters, and the Elgin "Deconcentrator" equipment for steam plants.

No. 490. The Barnstead Still & Sterilizer Company has released a new bulletin on the latest models of the **"Longwood" Instrument Sterilizer,** which uses hot oil as the sterilizing medium. Photo-micrographs are used in the bulletin to show the protective feature of hot oil.

No. 489. "The story of the Electro Sheet", a modern **rubber-electric heating pad,** has recently been published by The Seamless Rubber Company.

No. 485. General Electric X-Ray Corporation has for distribution an eight-page book on its RT 1-2 Rotating Anode Coolidge Tube, an **X-ray tube** to cover the entire field of diagnostic roentgenography.

No. 483. **"Pipe Repair Handbook"**, published recently by M. B. Skinner Co., will be of interest to individuals responsible for pipe line maintenance. The handbook discusses all the various kinds of leaks in pipe lines, joints of various kinds, and discloses how repairs may be made without service interruption.

No. 479. **"The Care and Handling of Hospital Rubber Goods"** has been published by the Surgical Division of the Miller Rubber Company, Inc. The booklet will be of considerable value to those in the hospital whose job it is to obtain the maximum use from rubber goods.

No. 474. **"Test by Temperature."** A pamphlet which describes the usefulness and accuracy of the Lag Thermometer as the proper method for checking sterilizing technique in autoclave sterilization. Wilmot Castle Company.

No. 473. Two booklets have been published recently by Westinghouse X-Ray Company, Inc., on its new low-priced **X-ray unit, the Pandex.**

No. 471. Four-page circular issued recently by the Inland Bed Company illustrates and describes the new **Inland sliding portable bed sides.**

No. 467. Complete catalog of products, illustrations and descriptions of the many **Curity ready-made dressings and dressing supplies.** Lewis Manufacturing Company.

No. 465. Hoffman-La Roche, Inc., has released the 1937 list of prices for its line of **Roche hospital products.** This is the first price list issued by this company in five years. The new 12-page booklet also serves as a catalog of Roche products.

No. 464. Engineering and installation **data for sterilizing equipment** will be gladly furnished by the Wilmot Castle Company. This firm invites correspondence relative to problems dealing with sterilizer installations. Consultation is without obligation.

No. 463. Catalog of **Boro Suture Needles** published reecntly by the Boro Surgical Company, contains price list and illustration of firm's line.

No. 461. Two descriptive folders covering the Angle line of **institutional furniture** are available for distribution. James L. Angle Company.

No. 459. **"Hospital Service Book and Catalog No. 3,"** issued by Johnson & Johnson, contains editorial material about surgical dressings, sutures, etc.

No. 458. **"Case Studies,"** a booklet by an authority on medical records which tells what constitutes a good case history and describes its use and value. Physicians' Record Co.

No. 453. **"Feeding for Health."** 20 pages of illustrated information on the achievement of higher standards of food service at low cost. A score of actual photographs and architects' plans of Pick kitchen installations in modern hospitals are included. Bedside Service, Cost of Operation, Space Allotments, Sanitation, Personnel Dining Rooms and Plan-

ning New Hospital Kitchens comprise but a few of the many subjects covered. Albert Pick Co., Inc.

451. **"The Modern Method of Controlling Sterilization."** A descriptive and informative pamphlet which explains the Diack Control and indicates precautions for its proper use. Included are many interesting facts concerning the characteristics and correct operation of small and large autoclaves, and the use of drum and other types of sterilizing containers. A. W. Diack.

No. 447. A 64-page book, entitled **"A Textbook on Sutures,"** containing the historical and manufacturing background of Curity sutures, as well as full details of their inspection, the operation-room preparation of catgut, the selection of catgut for sutures and ligatures, and explanatory chapters on absorbable and non-absorbable sutures. This textbook, profusely illustrated, was written by Paul F. Ziegler, Director of Research of the Curity Suture Laboratory. Published by the Lewis Manufacturing Company.

No. 445. **"Floor Reconditioning."** Descriptive material concerning the full line of floor maintenance machinery manufactured by the Lincoln-Schlueter Floor Machinery Company. Sanding, Steel-Wool Cleaning, Polishing and Scrubbing machinery is detailed and illustrated in this catalogue.

No. 444. A series of brochures describing the following **Curity products:** Layettecloth Diapers for hospitals, Lisco and dressing rolls, selvage gauze, bandages, cotton balls, Cellucotton absorbent wadding, Curity gauze, gauze and Lisco sponges, combination pads and rolls, dressings simplification, orthopedic products. Published by the Lewis Manufacturing Company.

No. 441. **"Sanitation Products for the Hospital."** A complete catalogue of Surgical and Baby Soaps and their dispensers, Baby Oil, Disinfectants, Floor Finishes, Floor Waxes, Furniture Polish, and other Hospital and Institutional supplies. The Huntington Laboratories.

No. 440. **"Relating to the Selection, Arrangement and Installation of Sterilizers."** A twenty-four page booklet containing 38 drawings and plans of various types of sterilizer, urinal, autoclave, and condenser units, as well as floor plans of typical installations. American Sterilizer Company.

No. 436. An eight-page booklet describing and illustrating uses and installations of **Acousti-Celotex** in hospitals. The manner in which this material acts and methods of its installation are completely described. The Celotex Corporation.

No. 429. **"Vitamin C—Cevitamic Acid, Synthetic."** Nature, chemical characteristics, indications for administration, diagnosis of vitamin C deficiency, and the employment of the synthetic in a number of other conditions is discussed interestingly in this pamphlet. Hoffmann-La Roche, Inc.

No. 428. **"Vitamin C Titration** with Dichlor-phenolindophenol—A Method for the Diagnosis of Prescorbutic Conditions." Written in non-technical language, this pamphlet clearly explains the technique its title indicates. A bibliography of literature on this subject is also contained in the booklet. Hoffmann-La Roche, Inc.

No. 424. **"Why Matting?"** a four page folder issued by American Mat Corporation, describing the advantages of rubber matting for use in building lobbies.

No. 422. **"Program Sound Systems."** A descriptive, illustrated twelve-page booklet, explaining the application of the Western Electric Company's sound distribution system.

No. 413. **"Standardized Hospital Record Forms."** Approved forms for professional service, administrative, accounting and all other departments. Physicians' Record Co.

No. 412. **"Alphabetical Indexing,"** describing the alphabetical disease and operation indexes; also other essential indexes as statistics cards, patients', physicians', X-ray and laboratory. Physicians' Record Co.

No. 407. A series of brochures describing the following **Curity products:** Sterilization and bacteriological control, plain and chromic catgut, the advance in absorption control, gastro-intestinal sutures, dermal and tension sutures. Published by the Lewis Manufacturing Co.

No. 404. **"Modern Surgical Illumination."** A new pamphlet describing recent and important developments in surgical illumination, prepared by the Wilmot Castle Company.

No. 392. **"Maintenance Cleaning Illustrated."** This booklet covers the entire field of maintenance cleaning. J. B. Ford Co.

No. 376. **"Wyandotte Products for Hospitals** and Institutions" explains how all cleaning in the hospital and institution can be done, and how every rule of thorough, safe and economical cleaning can be easily followed. The J. B. Ford Co., Wyandotte, Mich.

No. 252. **"Scientific Hospital Meal Distribution."** Swartzbaugh Manufacturing Company.

When You Plan to Buy

you'll find valuable help in the booklets and pamphlets listed. They are published by manufacturers and dealers serving the hospital field and contain much useful information. Circle the numbers of those you want. They will be sent to you without obligation.

498	490	467	451	428
497	489	465	447	424
496	485	464	445	422
495	483	463	444	413
494	479	461	441	412
493	474	459	440	407
492	473	458	436	404
491	471	453	429	392

376 252

HOSPITAL MANAGEMENT,
612 N. Michigan Ave.,
Chicago, Illinois

Please see that the items whose numbers I have circled are sent to me without obligation.

Name .....

Hospital .....

Address .....

IN THE SUPPLIERS' LIBRARY . . FREE . . ASK FOR THEM

Hospital Management's EDITORIAL PLATFORM

1. To elevate the standards of hospital practice.

2. To help in bringing good hospital service within the reach of every man, woman and child.

3. To help physicians, nurses, social workers, dietitians and others having to do with the care of the sick and injured.

4. To assist trustees of hospitals in better understanding their duties, responsibilities and relations.

5. To stimulate the better training of hospital superintendents.

6. To promote the education of the public regarding hospitals.

As The

CRITICISM OF THE HOSPITAL

» » At the present time, when there is so much general discussion with regard to the care of the sick, it is inevitable that the hospital should come in for its share of criticism. It is a pity that such criticism should be published in the press and in popular magazines, since they tend to weaken that confidence which is so beneficial to both the public and the institution and which those concerned with hospitals are trying to deserve and build up. However, there is little or nothing that we in the hospital field can do in the matter. We cannot prevent publication of critical articles, nor stop verbal criticism.

We can, however, benefit from criticism if we use it in the right way. Every critical statement reveals a weakness in our system or in some individual hospital. If these are taken as a basis for self survey, they will be useful; if ignored, they merely do harm.

With this thought in mind we have gathered together a few of the criticisms which we have read or have heard expressed, and present them with just one objective. We suggest that, taking the points listed as the nucleus and adding to them as local conditions suggest, each hospital administrator make a systematic self survey to determine: (a) if the criticism is applicable to his or her own institution; (b) to find and apply the remedy.

1. The patient selected his physician by reputation and feels that he received very poor treatment.

The hospital government is responsible for the competence of the members of its medical staff and should know that their work will be up to recognized standards. Members of the medical staff should be selected because of proven efficiency, not on reputation gained by impressions.

2. Reasonably trustworthy evidence is presented showing that the physicians are fee splitters.

In the face of sufficient evidence, appointment to the staff should be cancelled and the physician or physicians denied the privileges of the hospital.

3. The patient, although in pain and physically incapacitated, was not assisted from the stretcher to bed.

This is selected as an example of the lack of thought for the patient's comfort which might occur. It should be the specific duty of some member of the personnel to give such assistance as the patient may require in the interest of his comfort and safety.

4. The hospital is noisy. Loud talking is prevalent, dishes and carts rattle.

Most noise is due to carelessness and is therefore preventable. Every person in the hospital should be taught the necessity for avoiding all unnecessary noises.

5. A persistently noisy patient was allowed to remain in the ward.

Such a lack of consideration not only makes other patients irritable and restless, but has a definite effect in retarding recovery. Sufficient single rooms should be provided to accommodate this type of patient and that mentioned in the next paragraph, even though they are in the free category.

6. A patient quite manifestly psychotic was kept in the open ward and eventually developed an acute mania.

We are not among those who believe that certain types of psychoses should not be treated in the general hospital, but we believe that proper accommodation should be provided. Imagine the nervous tension of a helpless patient living in the same room as a psychotic, with the constant fear that he will become violent and dangerous.

7. An emergency case brought in during the night was examined in the ward, the examination being carried on with much loud talking and other noise.

Surely some place can be found where an emergency can be cared for without disturbing all the others in the ward. At least, the examination can be conducted quietly.

8. A patient habitually demanded and was given a bedpan at mealtime.

Usually the complaint is that a bedpan cannot be secured when it is needed, but could anything be more unappetizing than a bedpan at mealtime?

9. The patient was kept waiting two hours in the X-ray department, the hard and narrow stretcher aggravating the pain which he was suffering.

Delays in departments such as the X-ray are inevitable, but in those cases in which such delay aggravates pain or is otherwise harmful to the patient, they can and should be avoided.

Many other criticisms could be listed but we have discussed enough to convey the underlying idea. One obvious remedy lies in making frequent self appraisals in each hospital. We must have public confidence and support but we can deserve and gain these only by eternal vigilance to be certain that there is no remediable defect

in the equipment and organization of the hospital and that a spirit of consideration for the welfare of the patient pervades the entire institution.

HOSPITAL PHARMACY

» » In many instances the hospital pharmacy is in the position of a neglected stepchild. It is quite true that in the small institution the maintenance of a pharmacy is economically an unsound policy and these carry only stock solutions in a drug storage room, sending all prescriptions to a licensed pharmacist for compounding. The large hospital maintains a regular pharmacy with a qualified pharmacist in charge.

The hospital in between these extremes, that of average size, is the one that really offers a serious problem, since many prescriptions must be compounded and large quantities of stock are consumed, yet the volume of work is not sufficient to warrant a full-time pharmacist. In some cases the problem is solved by employing a registered pharmacist on a part-time basis, but all too often prescriptions which require compounding are sent to an outside pharmacy while stock solutions, ready made prescriptions and similar items are in charge of an intern, or some other person of responsibility.

We consider this to be a serious and dangerous situation. We question both the advisability and the legality of allowing any drugs to be compounded or issued except under supervision of a person who has had the requisite training. Mistakes have been made in such simple dispensing as stock solutions and ready made prescriptions. Certainly such control is illegal. We believe that the law is the same in all states, requiring that only a licensed pharmacist shall dispense drugs and that the original prescription be kept on file in the pharmacy.

It is, therefore, our belief that compounding and issuance of all drugs should be under control of a licensed pharmacist in every hospital regardless of its size. In the small or medium sized hospital this can always be arranged with a local pharmacist who will either carry the stock for the hospital or spend part of each day in the institution's pharmacy and control it. It is true that this will add slightly to the cost, but the added safety is well worth the extra expenditure and the pharmacy can always be made to pay dividends.

We note that the American Hospital Association has made the first effective move toward recognition of the problem by organization of a subsection on pharmacy. The American Pharmaceutical Association also has a well established subsection on hospital pharmacy. The committee on pharmacy of the A. H. A. in its second report, 1937, has called attention to "unsatisfactory conditions", and there can be no doubt that remedies will be found. In the meantime, however, the question is of sufficient importance to warrant immediate and serious consideration by the management of every hospital.

AIR CONDITIONING

» » On superficial thought the approach of winter may seem to be an inopportune time to discuss air conditioning, but we do not believe this to be the case. Air conditioning implies removal of foreign solids and gases from the air and regulating the amount of moisture as well as cooling it, and the first two are more applicable to winter conditions than to those of summer.

That partial or complete air conditioning is so desirable as to be almost a necessity has been recognized by hotels, restaurants and similar business enterprises. The hospital has been slow to take any action in the matter; yet there is no place in the world where it is more needed. The individual, when he is well, may suffer from the heat and from impure air, but death from this cause is not common. On the other hand, the sick person has a lowered resistance to all harmful environment and we have seen patients in whom excessive heat was the deciding factor in the struggle between life and death.

Air conditioning may be from a central plant or by local units. The central plant is expensive and few hospitals are in a position to afford a complete installation. For those who can afford a central plant, winter is the best time to have the work done.

The local unit still costs more than it should and no doubt the price will be lowered as time passes, but it is effective and has the advantage that it can be moved about and can therefore be used to help the seriously ill patient. If ways and means are canvassed during the winter, it will probably be possible to secure one or more local units before the heat of next summer.

Hospital Management extends Christmas Greetings to its co-workers in hospitals, and wishes for them a constantly increasing degree of success in effectively caring for the sick during the coming year.

Christmas IN THE HOSPITAL

By T. R. PONTON, M. D.
Editor, HOSPITAL MANAGEMENT

» » » FOR CENTURIES Christmas, the birthday of Christ and therefore inseparably linked with the salvation of the soul, has been set apart in all Christian countries as a season whose main objective is the bringing of happiness to others. Certainly nothing could be more appropriate than for the hospital, that institution of our civilization consecrated to the salvation of the body as well, to devote special effort to bringing happiness and joy to those confined within its walls at the Christmas season. It is quite true that in the hospital there cannot be that degree of hilarity to which the world has been accustomed at this time, but that need not mar the happiness which can be brought to those who, because of illness or disability, cannot be with their families.

As with everything else in the hospital, the patient is the first consideration. Many can be moved to wards or other central places and allowed the privilege of joining in a community celebration. Some will be ambulatory; others will come in wheel chairs, while in some instances it may be possible to move bed patients to the central place. For these, large Christmas trees can be set up and those of the patients who are able, get a great deal of pleasure in the decoration.

Some patients in the wards selected as centers may have to be transferred temporarily to private rooms in order to avoid a disturbance which might be harmful to them in their illness, while others who are already in single rooms will remain there but even to these the day can be one of pleasure. As a beginning, a small Christmas tree can be provided for each room.

A small gift for each patient can always be procured and makes the patient feel deeply the thoughtfulness of those who have been instrumental in securing the gifts. For those who must be kept apart, none is too ill to enjoy a tiny, glittery tree on the bedside table. Of course, other appropriate decorations can be everywhere in evidence.

The day may open with the singing of carols. Perhaps there is a group of nurses who sing well together, but if there is not, it is always possible to secure singers from the community. To be awakened in the morning by the soft music of one of the many beautiful carols immediately sets the day apart.

Then Santa Claus comes around. He must be clever and tactful. First, of course, is the distribution of gifts from the larger trees, but the seriously ill and those who for other reasons are by themselves must not be neglected. Santa requires a lot of tact and knowledge of the condition of the patient in order to temper his greeting to that condition.

Christmas dinner can always be planned to suit the occasion. Many hospitals make it a family affair by carving the turkey at a table set up in the ward, members of the governing body and of the medical staff officiating as carvers. Perhaps this is not possible, but at least the trays can be made to look like Christmas, by the addition of a

Christmas would not be properly celebrated without its brilliant tree and many gifts. The pictures of these two essentials are published by courtesy of the Hospital and Home for Crippled Children, Newark, N. J.

Christmas card as well as by the use of color in preparing and serving the delicacies which accompany the inevitable turkey.

While the patient is the first consideration at Christmas as at other times, the personnel is not to be forgotten. As many as possible should be allowed off duty, taking care to select for duty, as far as possible, those who cannot get home for the day. Probably Santa Claus can visit the Christmas trees in the nurses' home and staff dining rooms on Christmas Eve and distribute the gifts.

Just a word about the gifts, concerning which it is wise to take two precautions. Be sure that everyone is remembered, so that there are no heartaches; also, do not allow expensive gifts to heads of departments and others. All too often some employee receiving a very low wage feels obliged to contribute more than he or she can afford, thereby working a definite hardship. Among the personnel will exist real friendships which create a desire to give more elaborate gifts, but this should be quite apart from the hospital celebration.

It is all a lot of trouble but it is worthwhile. There is no greater joy in life than to see the faint, sweet smile of utter happiness on the face of a sick child as he lies looking at his glittering little Christmas tree and to know that one has had a part in creating that happiness. It is almost as great a source of satisfaction to watch the look of content come to the face of a seriously ill adult as he or she realizes that the people of the hospital have given time and thought to the pleasure of the patient as well as to his comfort and safety.

Christmas in a children's hospital, as told by Adelaide H. Guthrie, R. N., superintendent of the Hospital and Home for Crippled Children, Newark, N. J.

The tapestry of the History of Christmas is finished and hangs for ever on the wall of Time—a thing of lasting beauty. Gentle hands, tender in service and in sympathy are renewing it each year and through its many colors runs the golden thread of Love—unselfish Love—that gives, that soothes, that uplifts.

Santa Claus has visited the Hospital and Home for Crippled Children for the past forty-five years, at first in a very small way, but as the years passed the hospital grew larger and at present we are making an average of eighty crippled children happy at this glorious season. Because of the untiring efforts of our Ladies' Board of Managers and many kind friends, we carry our work into our clinics, sending at least one-hundred and fifty dinners to the most needy families and a package of clothing to all employes' children who have not reached the age of fourteen years.

During the holiday season the hospital is a miniature fairyland. Each ward is gaily festooned with decorations made by the children and last but not least a brightly

(Right) The Christmas tree and packages of gifts prepared for distribution in St. Mary's Hospital, Minneapolis, Minn.

(Below) A group of happy children who have kept an appointment with Santa Claus in a New York Clinic.

lighted tree, furnished us by the Newark Park Commission. We want the children to feel they are a part of these gay activities and encourage all who are able to take an active interest in making things as attractive as possible for Santa.

While this is being enacted throughout the building we are busy behind the scenes decorating one large dormitory which the children do not see until almost time for Santa to appear.

Each child is allowed to ask for one gift he or she would really like to have, and is given one other together with a box of candy and a stocking filled with fruit and nuts. These are placed by Santa under the large tree in the decorated dormitory and after a brief program, usually in the form of a little play given by the children, Santa rushes in midst the jingling of bells and the fun begins. After the toys have been distributed, ice cream and cake is served, for whoever heard of a party without ice cream?

Needless to say this is a rather strenuous day for the kiddies and they are quite ready to be popped into bed and are soon lost in dreams of Santa, toys, turkey, and many other good things they have had.

The dormitory is left for the children to play in during

(Continued on page 30)

The upper photograph is of a group of children in the Home Department of the Hospital and Home for Crippled Children, Newark, New Jersey, going to the Christmas Party. (Center) A group of younger children apparently look for Santa. (Below) Santa Claus comes to the Hospital and Home for Crippled Children.

The Christmas party is the brightest spot in the hospital year. The patients come unassisted or on crutches; some are in wheel chairs; a few may be brought in their beds, but all whom it is possible to move to the selected center get there by one means or another.

Personnel Management IN THE HOSPITAL

By FRANK J. WALTER
Superintendent, St. Luke's Hospital, Denver, Colo.

» » » DURING the nineteenth and twentieth centuries, business enterprises have expanded greatly in volume, from the small shops with few employes to the great industries now employing an army of workers. This growth in the size of industries has created the problem of personnel management, which practically all the large industries have recognized, and have established special departments to handle. Because of the fact that the hospitals' expansion has been much slower, and in view of the nature of the hospitals' work, the problem of personnel management has not reached the extent which it has in other enterprises. But at the present time many modern hospital administrators recognize this problem, and are giving it their attention.

In the industrial field this work has been turned over to trained administrators, but the employment of a trained personnel manager to handle the personnel problems of the hospital has not been universally adopted in the hospital field. Most of the hospitals of the United States are too small to afford the additional overhead of such an office, and, moreover, a great deal of the burden of personnel management has already been placed upon the department heads and the administrator. However, it would be well for the hospital whose personnel is large enough to warrant doing so, to seriously consider this plan which has been found worthwhile and profitable in the fields of industry.

Because of the complications which have arisen in society and its industrial relations, the government has imposed regulations; and any consideration of the subject "Personnel Relations" must necessarily give due consideration to the legislative regulations regarding the employe and the employer. Since individual employers are interested only in the laws which are in effect in their own states, no attempt will be made to discuss the local state laws except a few general principles which are accepted in every commonwealth.

The most recent enactment—the one claiming the most attention at the present time—is the National Labor Relations Act, commonly known as the Wagner Act. The law in itself does not state whether or not hospitals are exempted from complying with the provisions of the Act, but a recent ruling has exempted them from doing so. This Act establishes the right of collective bargaining and creates a board to make rules and enforce the provisions of the Act. This board has no power to enforce its regulations except upon appeal through the local courts.

Most states have enacted through their assemblies little Wagner acts, the purpose of which is to include industries of that state not engaged in inter-state commerce under the same regulations as the national act. The New York enactment is a model of such, and in it hospitals are definitely exempted.

While the hospitals are exempt from the provisions of the Wagner Act, the effect of the Act upon outside industries will surely affect the hospitals indirectly. The hospitals cannot isolate themselves, as the effect of the workers organizing in the community will reflect itself among the workers of the hospital. And, benefits gained by employes on the outside will be demanded by the employes of the hospital doing the same type of work.

The Social Security Act grants to employes of industries unemployment insurance and old age pensions. Under the provision of this Act, hospitals are exempt. This Act sets up a system whereby the employer and the employe each contributes equally to a fund which is to provide for the employe a benefit in his old age. The contributions are made on a graduated scale, increasing periodically until the year 1949, at which time the contributions will mount to three per cent of the individual's salary to be paid by both the employer and the employe. The second part of this enactment provides for unemployment insurance, the assessment being paid only by the employer, not the employe.

Even though hospitals are exempt from complying with the provisions of this regulation, it remains to be seen whether it is wise for them to accept this exemption. Again, competition with outside industries may force hospitals to accept the provisions of this act. If the employes who are working in the commercial industries, and who are subject to the provisions of this Act, accept it as a real benefit, the hospital employes will wish also to be included in its benefits. On the other hand, if the employes in the industries feel that their regular assessments are greater than the benefits they will receive from them, the hospital employes will welcome their exemption. The loss of mutual insurance protection which was in the past carried by many large industrial organizations for the benefit of their employes, but which was dropped when the social security laws became effective, may in the employe's mind offset any benefits which he would receive from the Social Security Act. Time alone will determine this sentiment.

At the present time there are no national enactments regarding maximum hours and minimum wages. Most of the individual states do have laws at the present time regulating the maximum hours and the minimum wages of employes, at least the women employes. In most cases, with the exception of the professional employes, this regulation does not apply to hospitals.

Presented at the Hospital Standardization Conference of the American College of Surgeons, Chicago, October 25 to 29, 1937.

There are also the Workmen's Compensation Insurance Laws, in effect in all states, which require the hospitals as employers to insure their employes against injuries occurring in the performance of their duties. There are also many local enactments, differing for each commonwealth, regarding the manner of payment, liens, and garnishment of employes' wages, but they are of too local a nature to be discussed here.

Personnel Relations

The most perplexing problem of hospital personnel management at the present time is the formation of unions, the recognition of such, and the possibility that employes will strike to enforce their demands. In industry this dispute has taken the form of a conflict between capital and labor, with labor's demands for what they claim is their due share in the profits of capital. In this lies the greatest difference between the hospital organization and the average industrial organization. Most of the hospitals are owned directly by the state or by groups of philanthropic or public-spirited individuals or organizations, not for profit, but for the purpose of aiding society. In other words, to quote C. Rufus Rorem, "Nearly all hospital capital has been invested on a community basis. The hospitals are social capital." There can be, therefore, no conflict between capital and labor, because there is no capital. Hospitals function equally for the destitute and for the wealthy. Therefore, because of this great difference between hospitals and industries, certain distinctions have had to be made. This has been recognized by the legislatures in enacting the laws, and unions entering the hospital field must also recognize this difference. Both the American Federation of Labor and the Committee of Industrial Organization recognize the difference between hospitals and industries.

Up to the present time, the experience of unions in hospital relations has been very limited, and where charters have been granted, the leaders of the industrial organizations—American Federation of Labor and the Committee of Industrial Organization—are not very much aware of the local hospital conditions. The attitude of these labor groups has been that they would not sponsor or promote the organization of unions among hospital employes, but that if the hospital workers approached these organizations asking for charters or affiliation, such would be granted. Within the last two years, charters have been granted by the American Federation of Labor and the Committee of Industrial Organization both to the professional groups and to the unprofessional workers. Some federal hospitals are organized under the National Federation of Federal Employes; and the state, county and municipal hospitals are being organized under the National Union of State, County and Municipal Employes Association.

The unions present three distinct problems to a hospital: First, the liability of the unions getting out of the control of their national organizations and committing acts not approved by those organizations. Second, the possibility of the strike, which is the union's chief weapon in labor disputes to force their demands. Third, the union's demand for the right to supervise the employing and discharging of employes.

A definite example of the first problem was found in the case of the Hospital Employes' Union of New York, Local 171. This Union was a member of the American Federation of Labor, and in spite of the stand taken by that organization—that it would not tolerate strikes among hospital worker's unions—the local representatives caused a sit-down strike in one of the Brooklyn hospitals. Their charter was revoked, as the national organization did not approve of the action of the local representatives, but the fact remains that the strike did occur. Moreover, once a strike is declared, the revoking of the union's charter by the national organization will not stop local anarchy.

The San Francisco *Chronicle* of September 5, 1937, states that the hospital workers voted 192 to 90 in favor of using strikes to force their union demands, and by similar votes also favored the use of picketing and boycotting.

During the World War the American Federation of Labor very patriotically and sincerely pledged the support of labor to the successful completion of the conflict; but in spite of the national attitude and in face of our national emergency local strikes did occur.

This leads to the consideration of the second problem created by the unions, the strike. The type of service which the hospitals render to the public is indispensable. An automobile factory may, because of labor disputes, cease production for a month, or a textile mill may stop work for a period of time; but for a hospital to terminate its activities with the suddenness which is done in the industrial disputes would affect the welfare of all its patients.

President Roosevelt recently stated that the employes of the government must not strike. The late President Coolidge was elevated to national fame for his attitude taken in the Boston police strike. If it is against public policy for the guardians of peace and safety to strike, the same must surely hold true for those engaged in the preservation of human life. The courts of New York have held in the last few months that it is against the public policy for strikes to be tolerated in hospitals. When an employe accepts employment in a hospital, therefore, he must do so with the understanding that the nature of the work he is undertaking is such that a strike

The question of personnel management is always of importance in an institution having as large a number of employes as does the hospital, but with the present labor unrest it is even a greater problem than in normal times. Hospital Management is fortunate in being able to present to its readers a paper on this subject prepared by one who has given it a great deal of study.

cannot be justified. If this principle is true, then labor's chief defensive weapon, the strike, cannot be used.

As intolerable as a hospital strike is, it would seem that the picketing of a hospital during the strike is even more deplorable. Picketing causes a strained and intense attitude about a hospital, not only among the employes who are willing to work in spite of the picketing, but also among the patients who have a feeling of unrest and insecurity. This is intolerable because it is so imperative that the patients have a feeling of peace, quiet and security in order to recover. The employes who do not have enough conscientious feeling of responsibility toward the patients to remain on their jobs, should at least have the decency to stay out of the way and allow other persons who do have that sense of obligation and willingness to take up the tasks.

Again, because of the vital nature of the hospital work, the unions' demand that they supervise the hiring and discharging of employes cannot be recognized. The hospital executives must be free to hire those employes who will give the most conscientious and efficient service to the patients, so that their chances for recovery may not be hindered or retarded. Likewise, the executive must be free to remove from the employ of the hospital, any individual who impedes or endangers this recovery through neglect of his duties.

Thus, the problem before each hospital administrator is whether he should oppose, encourage, or remain neutral toward the organization of unions among his employes. In determining his attitude, he should be fully aware of the results of unionizing in his hospital. From the answers of hospital administrators given to a recent questionnaire, the conclusion was drawn that most of the administrators did not realize the effect which unionizing would have upon their organizations.

A superintendent of a hospital which has actually gone through a difficult period with a hospital union, declares that considerable thought must be devoted to the matter before formulating a definite program of action to meet forces that may alter the structure of hospital organization and operation. He does not believe that a neutral stand can be long maintained and it is just as well to determine which cou se will serve the best interest of the hospital and the sick.

Referring to a recent decision of a New York court, quoted from the August 28, 1937, issue of the Brooklyn, New York, *Tablet*: "This decision definitely excludes on the grounds of public policy the voluntary hospitals from the operations of the Little Wagner Act in favor of unionization. Because the health of the community, and particularly of the indigent and the needy, depends so vitally upon the ability of voluntary hospitals to carry on, even under constant financial loss, the ordinary conditions which call for unionization cannot be said to exist. By reason of the charitable work done by these institutions, the general public demands of hospital employes a consecrated, disinterested service which is a thing quite distinct from the ordinary relations between employer and employe in industry."

If the hospital does not recognize the place of the union in its organization, and demands the protection against strikes from its employes, then in turn it must assume a much greater responsibility for the treatment and welfare of its employes than that assumed in the industries. The hospital administrator should not refuse to hear and consider the demands made by his employes. It is the employes' right to discuss with the management matters affecting his employment, wages, hours, and living conditions. Hospitals should negotiate with their employes, subject to the recognition of the principle that the right to work is not dependent on membership or non-membership in any organization. Most of the outbursts have been caused by the administrator's taking an arbitrary stand and refusing to grant an audience with the employes when they sought to present their grievances and requests. It should, on the other hand, maintain a sympathetic understanding of the employes' conditions, and do everything within its power to maintain reasonable and satisfactory working conditions. If the hospital administration feels that the demands of its employes are excessive and cannot be met, or if the hospital employes feel that they must have additional concessions, both groups must be willing to subject these differences to arbitration at the hands of impartial and respected arbiters, who have an understanding not only of the hospital's and employes' viewpoints but of the welfare of the community as a whole. Repeatedly it has been demonstrated that arbitration between the employes and the employers was not impossible, and satisfactory results have been accomplished, avoiding the disturbances of an industrial dispute. Without doubt, if the hospitals would take the initiative in removing wherever possible any justifiable causes for complaints, the formation of unions would be unlikely to occur. But if a hospital does have questionable conditions, which it neglects to remedy, it is providing an ideal situation for the development of the unions.

We have considered the hospital as differing from the industrial enterprises, from the financial and social points of view. Even with these differences, we cannot be a private industry of our own. The supply and demand for labor affects us just as much as it does the industries. The hours of labor, working conditions, and wages paid for similar employment in industries are bound to affect the hospitals more than the hospitals' conditions and wages will affect the industries. Hospitals make a mistake in comparing wages paid in one hospital with those paid in other hospitals for similar work. They should on the other hand compare hospital wages with those paid in the outside industries for similar work. It is foolish for the hospitals to attempt to pay their employes less than those employes can secure elsewhere, because under that condition the employes will stay only long enough to gain experience at the hospital's expense and then capitalize upon this experience in the outside business world at their first opportunity. There is no need to discuss the losses and other bad results from a large turnover of employes. The hospital should pay not a premium but sufficient wages to obtain and retain the services of the best type of employes to be had. It is a known fact that low wages hire the costliest type of employes.

The hospital's excuse that it is a charitable institution is not a valid reason for paying lower wages than the other industries pay for similar work. Not every hospital worker receives the satisfaction of coming in direct contact with the patient. The laundry worker, for instance, does not get close enough to feel the satisfaction of ministering to the sick. It is well and good to say that these

(Continued on page 48)

HOSPITAL EMPLOYES AND Workmen's Compensation

I. H. Rubenstein, a member of the Chicago Bar, has devoted a great deal of study to the compensation acts of the different states, and presents his conclusions and opinions in the accompanying article.

» » » THE QUESTION that this article seeks to answer is whether a hospital may be an "occupation" which comes under the workmen's compensation act. The importance of this question lies in the fact that it determines whether it is necessary for a hospital to provide itself with workmen's compensation insurance. Because of the scarcity of cases on this question, and the difference of the several workmen's compensation acts in their definition as to what constitutes an "occupation", this article can be considered only as an indication of what the law is on this subject. An examination of the few cases in point not only demonstrates this difference but also points out the factors which determine this particular question.

In the leading case of Hahnemann Hospital v. Industrial Commission, [1] claim for workmen's compensation was made against the Hahnemann Hospital, an Illinois charitable corporation, located in Chicago. This hospital, a seven-story structure, is equipped with freight and passenger elevators, engines, high pressure boilers and electrical signal and lighting apparatus. The city ordinances provide that hospital buildings, of more than three stories in height, should have a fireproof shaft for the elevator, be equipped with fire escapes, and that the boilers, engines and electrical apparatus should be inspected at certain intervals by proper public authorities. In holding that the Hahnemann Hospital is an "occupation" under the Workmen's Compensation Act, the Supreme Court of Illinois declared that "the mere conducting of a hospital for treating injured and sick persons . . . . is not, in itself, extra-hazardous, yet a hospital is named in the statute as one of the enterprises which may become extra-hazardous when it is conducted in a building of a stated height and in a city where municipal ordinances are or shall be imposed 'for the regulating, guarding, using or the placing of machinery or appliances or for the protection and safeguarding of the employes or the public therein'. It cannot be truly said that conducting a hospital in a populous city like Chicago, in a seven-story building and under ordinance regulations such as are imposed on appellee, cannot be extra-hazardous, although such a business or enterprise would not be extra-hazardous or even hazardous, if conducted in a one-story building without such regulations and without being surrounded by dangerous machinery, equipment and appliances made serviceable or driven by electricity or some other extra ordinarily dangerous agency or power . . . . . Under the evidence in this case, we think it clearly appears that the hospital of appellee, i. e., the business or enterprise of conducting a hospital by it in the building, with the machinery, appliances and equipment therein used, is in fact, extra hazardous within the meaning of the statute. Many of its employes are engaged in handling, repairing and operating the dangerous machinery, equipment and appliances and are exposed to the dangerous agency or power which drives or makes serviceable such equipment and appliances. Not only are those employes exposed to such dangers, but all other employes therein are more or less exposed to them. Extraordinary care and skill are required in the building and management of said equipment and appliances to prevent serious accidents". In substance, the holding of this case is that a hospital of large size (possibly more than three stories in height) and containing considerable machinery, appliances and equipment, whether operated for profit or as a charity, and located in a large city, is an "occupation" under the Illinois Workmen's Compensation Act. This case also holds that an ordinary small hospital (possibly three stories or less in height) conducted either for profit or as a charity, is not such an "occupation" which comes under the act. There is dictum in this case to the effect that if the Hahnemann Hospital, or a hospital of even larger size, were located in the country or in a small town, such a hospital so located would not be an "occupation" under the act.

The case of Mayor and City of Baltimore v. Smith [2] involved a claim for workmen's compensation against the Baltimore City Hospital, a public charity. The Maryland Workmen's Compensation Act applies to employment in an "industrial enterprise". In holding that the hospital was not an "occupation" under the act, the Maryland Court of Appeals declared that "it is obvious that a hospital is not an industrial enterprise . . . . . Nor does the chance of infection and disease convert . . . . . a hospital into . . . . . an industrial enterprise". Despite the paucity of the court's reasoning on the pertinent point in question, the holding of this case appears to be that in Maryland a hospital, regardless of its size, amount of machinery, or equipment, appliances and location, and whether operating as a charity or for profit, is not an "occupation" which comes under the act. This case reveals that the Maryland judiciary is very liberal in its attitude toward hospitals located within its borders.

In Rugg v. Norwich Hospital Association [3], Claim for workmen's compensation was made against the Norwich Memorial Hospital, a non-profit corporation. The New York Workmen's Compensation Act applies only to a

(Continued on page 54)

[1] 282 Ill. 316, 117 N.E. 767 (1918).

[2] 177 Atl. (Md.) 903 (1935).

[3] 205 App. Div. 174, 199 N.Y.S. 735 (1923).

FIRE Protection

» » » EVER SINCE Mrs. O'Leary's cow kicked over a lamp and started a construction boom in Chicago, engineers have been devising technics and machines to prevent fires and to stop them once they start. But in spite of all their efforts the occurrence of fires is greater here than in any other country in the world. Especially is this true of hospitals which lead all institutions in the number of fires and loss of life and property. Why should this be? We boast of our high standards of hospital services; we lavish medical science and nursing care on a patient to save him from the abyss only to sacrifice him later on the altar of fire. Perhaps this business of delivering human beings from ills of the flesh has blinded us to other dangers intimately connected with our hospitals. Perhaps hospital supervision is as culpable as defective construction. In any event the prudent superintendent should evaluate his fire protection before it is too late.

The fire problem resolves itself into the following components: fire prevention, fire hazards, fire warning devices, fire fighting apparatus and fire escape facilities. Fire prevention is realized insofar as the building is constructed of fire resistive materials, as the degree to which cleanliness and order are observed and as to frequency of inspection of plant and equipment by accredited engineers. In addition it is well to be assured that bins and storage rooms are properly ventilated; that combustible waste is contained in metal receptacles; that steam pipes passing through walls are insulated and collared; that use of rubber hose on gas connections is discouraged; and that electric circuits are not overloaded. Further pre-

The upper photograph illustrates the danger of open stairways and the fact that they are worthy of practically no recognition as a means of exit in case of fire. The obstructing stairway landings are an additional hazard. The center photograph shows characteristic damage to the interior of a fire-resistive building. The structural steel was not affected; repairs were confined to replacing fireproof and finish. Owing to fire-resistive construction this fire was confined to the room of origin. Below is shown the fatal corridor on the third floor of the Manhattan State Hospital for the Insane, where 27 persons met death in 1923. On the opposite page is a view of the ruins of the frame annex building of the Illinois State Hospital for the Insane, in which 18 persons were burned to death on December 26, 1923. Photographs courtesy National Fire Protection Association.

In Hospitals

By E. RAY GRAM
State Department of Social Welfare, Albany, N. Y.

vention is afforded by the use of fire retardant mattresses and paints. Since the majority of fires originate from sparks falling upon roofs, it becomes imperative that roofing be fireproof and that spires and projecting points of the building be provided with lightning rods.

When the anaesthetic apparatus is electrically intercoupled and the operating room humidity is maintained at 60, danger from discharge of static is obviated. A portable humidifier is available for small hospitals and for those who find the cost of installing an air conditioning system prohibitive. Where artificial humidification is not used it is advisable to ground the patient, attendants and all apparatus. Electric switches used in the presence of explosive gases should be of the sparkless (oil of mercury) type, and adequate ventilation should be provided for the diffusion of spillway gases. A metal floor plate placed at the entrance to the operating room will draw off the static of persons and equipment entering the room. A recently publicized disaster should forewarn the careless surgeon never to employ a live cautery during gas anaesthesia.

A separate building is recommended for the heating plant and for the bulk storage of inflammables such as oils, anaesthetics, mops, polishing rags, etc. However, where this is impracticable they should be housed in unheated fire insulated rooms with exits leading directly to the outside.

Spread of fire may be checked by the installation of fire doors and the sealing off of old hot air conduits which have been replaced by other heating systems. Laundry chutes, dumb waiters and flues should be provided with cut-offs to prevent the passage of smoke and fire. Whenever glass is used in doors or elevators it should be shatter-proof. A night patrol should be detailed to clock each station from sunset to sunrise at regular intervals depending on the size of the institution. Excepting in Class 3 buildings (most hazardous) and in rooms where special hazards exist it is best not to post "no smoking" signs. When indiscriminately used they are usually an invitation to "aid one's digestion" in some nook where a resulting fire may go undetected. A smoking room set aside for employes and visitors with appointed hours for indulgence by the personnel will materially reduce hazards.

Among a multitude of fire hazards are: faulty electric wiring; unprotected electric motors; loose coupling on electric cable conduits; paint shop near to boiler room; paper and towels used as shades in contact with electric bulbs; cloths drying on steam pipes; rags in back of radiators; leaking oil barrels, alcohol drums and other inflammables; debris in elevator pit; combustibles under stairways; disorderly storerooms, basements and attics. Rats gnawing through electric insulation and spontaneous combustion of cosmetic rags in dresser drawers have caused more than one fire. Electric flat irons and open gas flames are more common offenders. So called fire proof buildings tend to give the administrator an undue sense of safety. But concrete has been spalled and steel supports have bent into fantastic shapes by high temperatures developed in intense fires.

Fire warning devices are many and varied, and range in complexity from the simple hand struck gong to the highly sensitive automatic systems. Whatever the type used it must be reliable and show speed in operation. Local fire authorities prescribe definite specifications in compliance with National Fire Protection Association standards, but material and installation should be approved by the National Board of Fire Underwriters. Since many hospital superintendents are not familiar with the workings of fire equipment a terse description will not be amiss. Alarm boxes are placed on the walls at strategic points throughout the premises not higher than five feet above the floor. They are installed for surface or flush mountings. The latter painted to harmonize with the surrounding color scheme is, unfortunately, in vogue in new buildings. This sacrifice of utility for beauty is tantamount to greasing the brakes because they squeak. There is no sound argument for an inconspicuous alarm box.

The manual alarm system is either coded or uncoded. In both, the technique of operation is identical, i. e., the box glass is broken, the hook is pulled and the alarm is sounded. The coded system indicates the location of the box pulled and the alarm is given in certain localities only. This precludes arousing the patients. Insertion of a special key in the box plus another pull of the hook causes a gen-

eral alarm throughout the premises and summons the local fire department. All boxes are connected to a control panel located either in the engineer's room or in the superintendent's office. A further extension of this principle is the group control system where more than one building is involved. Double circuits are here installed with the main circuit controlling alarms to a central station. The uncoded system does not indicate the location of the box pulled but causes a continuous signal to ring. This system may be used also to summon the local fire department. In the event of abnormal conditions obtaining in either system a trouble bell gives warning.

The automatic alarm systems consist of heat sensitive units which automatically detect the incipient fire and summon assistance. There is the rate of rise system which responds to an abnormal rate of rise of temperature so characteristic of all fires. In this type a pneumatic copper tubing one-twelfth inch in diameter, containing air at atmospheric pressure, is attached to walls and ceiling. With a rapid rise of temperature the air in the tube expands, causing an increased pressure which operates the alarm. In the fixed temperature system a thermostat is set to any desired temperature from 135 degrees up. The activating temperature either fuses a metal link or changes the position of a bimetallic strip, thus making or breaking the current and setting off the alarm. Electrical alarm connections are also affixed to the heads of automatic sprinklers. A telephone system intercommunicating with all salient points of the hospital is an essential adjunct to any fire warning device.

Heading the list of fire combative instruments is the twelve-quart water bucket, then the sand pail, axes and lances, standpipes and hose, automatic sprinkler systems and hand extinguishers. Be certain that the standpipe valves are not located higher than the average person can reach, and that they are furnished with a spanner and wrench and sufficient length of hose to reach all parts of the area to be served. Visual inspection of the hose should be supplemented with bi-annual tests using shut-off nozzles in order to determine capacity of the hose to withstand heavy water pressure.

There are extinguishing agents particularly effective for each class of fire, and a wrong choice may do more harm than good. The familiar soda-acid extinguisher if played on burning oil would spread the fire; if directed at a blaze rising from electrical machinery might prove fatal to the amateur fire-eater. In addition to being an excellent conductor of electrical current the soda-acid solution tends to corrode machinery. Be sure to test this extinguisher just before recharging; otherwise if inverted for test and then replaced for use corrosion may "fix" the cork in the acid bottle or plug the nozzle, thus creating a potential retard. Keep foamite extinguishers on hand in the operating room, kitchen, boiler room and drug room or wherever there is risk of fire from oil. The tetrachloride extinguisher is preferred where machinery is concerned. If extinguishers are placed where low temperatures may prevail, select a solution with anti-freezing components such as calcium chloride, carbon tetrachloride, etc. An extinguisher of less than two and a half gallons capacity is advisable because it is lighter and easier for nurses to handle. Distribution of extinguishers should be made according to the floor plan and the peculiar conditions extant. Know which one to use and get acquainted with its range, coverage and method of use. The National Fire Protection Association will gladly furnish instructions.

The weight of expert opinion rests on automatic sprinklers as the most efficient fire-fighting apparatus. Especially is their installation necessary in attics, basements, closets, storerooms, laboratories and stairways. This system should be inspected annually and a supply of sprinkler heads should be kept on hand.

Water supply and water pressure found to be under requirements should be supplemented by a water tower and pressure pumps. Water towers in rural communities should be heated in winter when the temperature drops below the freezing point. This is accomplished by jacketing the tower for passage of live steam or affixing an electric plate to the base. A clear path to outside hydrants should always be maintained. Fire equipment is not complete without a supply of smoke masks.

When to fight and when to flee belong to the niceties of decision. If, however, escape is indicated, ambulant patients might make their own decisions; indeed it might be expedient. In this case the following list of "shoulds" must be observed: exit signs should be placed over all doors leading to the outside; red exit lights should burn continuously; exit doors should be equipped with anti-panic bolts; alternate means of egress should be provided; and elevators should be in running condition at all times. A reasonable number of stretchers should be available for bed patients; at least a three-foot pathway between rows of beds should be clear; stairways, fire escapes and fire towers should be of adequate width and the turns should allow for the easy maneuvering of the loaded stretchers. The use of open outside stairway fire escapes is definitely contra-indicated for hospitals and is fraught with danger because of sleet, ice and snow. Since it is impractical to litter patients downstairs, vertical means of evacuation should be replaced by horizontal exits which have the advantage of ease and speed of movement and the protection of patient from exposure and unfavorable emotional reaction.

The patient's safety is too often assumed. The building may be fireproof but the patient isn't, nor is he immune to the lethal effects of smoke. The mere presence of fire equipment is no indication of protection unless its operation is understood. Thus the effectiveness of all fire apparatus and the despatch with which a fire situation is handled will depend on the degree to which the personnel has been trained. Rescuers must be mobilized with military precision and every man must discharge his duties efficiently when the emergency arises. But this is possible only where the fire drill is made part of the regular function of the institution.

Ultimately, the location of the hospital, the nature of the construction, the type of patient served, the peculiarities of the fire hazards and the proximity to a municipal fire department will determine, to a large extent, the nature of the protective system to be installed. However, if fire proof roofing is used exclusively, if the principles of good housekeeping are rigidly adhered to, if the circuits are not overloaded, if attics and basements are sprinklered, if plant and equipment are frequently inspected, if fire apparatus is maintained in working condition, if horizontal exits are provided, and if the personnel is fire-disciplined—then will casualties and money losses be reduced to a minimum.

In the News

Hospital Ass'n Conventions

» » The Colorado Hospital Association held its annual meeting in Denver on November 9 and 10. The officers for the ensuing year are as follows:

President, William S. McNary, University of Colorado School of Medicine & Hospitals, Denver.

President-Elect, Msgr. John R. Mulroy, Director, Catholic Charities, Denver.

1st Vice President, R. J. Brown, Porter Sanatorium, Denver.

2nd Vice President, Sister Mary Sebastian, Mercy Hospital, Denver.

Treasurer, Grange Sherwin, St. Luke's Hospital, Denver.

Trustee, Dr. Herbert A. Black, Parkview Hospital, Pueblo.

Executive Secretary, Walter Christie, Presbyterian Hospital, Denver.

» » The next annual convention of the New Jersey Hospital Association will be held at the Medical Center, Jersey City, N. J., Thursday, Friday, Saturday, June 2, 3 and 4, 1938.

» » The Mid-West Hospital Association will hold its next annual meeting at Hotel Kansas Citian, Kansas City, Mo., April 21-22, 1938.

New Equipment for St. Luke's Hospital

» » St. Luke's Hospital, already recognized as having one of the best radiological departments in the country, has put in new X-ray equipment valued at $175,000. The whole of the second floor of the main hospital is occupied by the department.

Hollywood Hospital Changes Ownership

» » On November 1, 1937, the Hollywood Hospital, Hollywood, Calif., was taken over by the trustees of the Presbyterian Hospital-Olmsted Memorial, under a thirty year lease and will be operated under the title of Presbyterian Hospital-Olmsted Memorial, Lessee Hollywood Hospital. Reverend Paul C. Elliott is executive secretary of the hospital and C. S. Pitcher will continue as consultant and administrator until the reorganization is completed about January 1, 1938, when Mr. Elliott will become executive secretary and administrator.

Emergency Lighting Equipment

» » St. Joseph's Hospital, Reading, Pa., has recently installed a complete emergency lighting plant. The system was installed by the hospital's engineers at a cost of $4,000 and is noteworthy in that it exceeds considerably the maximum state requirements.

The electricity for the unit is generated by a 20 kilowatt steam turbine generator, capable of supplying electric current for emergency outlets, such as halls, stairways and main corridors; may be used to generate power for all lights in use at time of normal power failure; may be used while system is in operation throughout the hospital; nurses' home, engine and boiler rooms and all patient's rooms with special provisions for operating, delivery, emergency accidents, and X-ray rooms. In short the system can supply power for all the normal lighting of the institution in the event of a power failure.

Another Move for Shorter Hours

» » The Alabama State Nurses' Association at its recent convention started a movement to work out a shorter schedule of working hours.

To Abolish Politics From State Hospitals

» » The Board of Control for State Hospitals in Arkansas has started a movement for political freedom in management and affairs of the State Hospital for Nervous Diseases. The most feasible phases of such board management will be compiled and recommended to the 1938 legislature for adoption in this state.

As at present under consideration, the plan will call for long-term board members on possible 3, 5, 7, 9 and 12 year terms, with governors privileged to replace by appointment only one member during a tenure of office. Superintendents would be under board control, and board operation and institution management would be similar to that now controlling the state Tuberculosis Sanatorium at Booneville and the University of Arkansas.

First Hospital Built in America

» » It appears to be definitely established that the first hospital to be built on the American continent was the Jesus Hospital in Mexico City, Mexico. Col. Edgar Erskin Hume of the United States Army is reported to have formally recognized this hospital as such. The institution is said to have been built by Cortez in 1524 and is still operating, devoting itself to the care of patients of both sexes needing medical or surgical treatment. The equipment of the hospital has been kept up to date and is modern in every respect.

Course in Hospital Administration

» » The Commonwealth Fund has awarded a grant to the University of Chicago making possible the continuation of the graduate course in hospital administration which has been given for the past three years at the School of Business. The grant will provide for the preparation of study materials, instruction, fellowships and scholarships. The course will commence on January 3, 1938, and will be given in cooperation with the American College of Hospital Administrators.

Physicians, nurses and laymen holding the University entrance requirement of a bachelor's or doctor's degree are eligible to make application. Many applications have already been received although the class is limited to eight students.

Doctor Arthur C. Bachmeyer, director of the University of Chicago Clinics, will be director of the hospital administration course assisted by Gerhard Hartman, acting executive secretary of the American College of Hospital Administrators, who will be associate director.

Health Talks

» » In the interest of preventative medicine and community health, Mount Sinai Hospital of Philadelphia is presenting its sixth series of free health talks. Medical topics of general concern are discussed by members of the medical staff in as clear a manner as is necessary for complete appreciation by the public. Sample diet trays, illustrative pamphlets or motion pictures supplement the lectures. There is also a short period allotted to the answering of questions. The 1937-38 schedule will consist of monthly lectures delivered on November 17, December 15, January 19, February 16, March 16, April 20 and May 18.

Providence Hospital, Columbia, S. C.

» » The cornerstone for the new Providence Hospital at Columbia, S. C., was laid on Sunday, Nov. 14, by the Most Reverend Emmet M. Walsh, D. D., Bishop of the Roman Catholic Diocese of Charleston. The hospital will have a capacity of 110 beds, with provision made for expansion as the need arises. Special and private and two and four-bed rooms are included in the specifications. The building will be entirely fire-proof. For the present no school of nursing has been provided, as the patients will be cared for by the Sisters and other graduate nurses.

Roche-Organon Company Formed

» » Hoffman-LaRoche, Inc., has announced the formation of the Roche-Organon Company, a new company which will undertake the manufacture and distribution of organon hormone products in America. This new organization is the result of plans recently completed in The Hague for collaboration of the Organon Laboratories of Holland with Hoffman-LaRoche, Inc., of Nutley, N. J., to make hormonal therapy more readily available to American physicians.

Association of Private Hospitals, Inc.

» » In celebration of five years of its existence, the Association of Private Hospitals of New York City, held a dinner on Tuesday evening, November 9, at the Hotel Alamac. A review of the work of the Association since its organization showed the tremendous progress which has been made. The Association of Private Hospitals, Inc., was organized to improve the conditions and to standardize the operation of proprietary hospitals in Greater New York. Harold Hays, M. D., F. A. C. S., has been president of the Association since its inception.

Starting with three hospitals, the Association now has twenty-one. It includes practically all of the private hospitals in New York eligible for membership under its requirements. These membership requirements which have been set up following conferences with the American Medical Association, the American College of Surgeons, and the American Hospital Association, afford the greatest safety for the patient and cooperation to the doctor.

Simplified Practice Recommendations

» » The Division of Simplified Practice of the National Bureau of Standards has announced that printed copies of Simplified Practice Recommendation R167-37 for Counter, Window, and Radiator Brushes are now available. Copies may be obtained from the Superintendent of Documents, Government Printing Office, Washington, D. C., for five cents each.

The current revision of Simplified Practice Recommendation R85-28, Adhesive Plaster, has also been accorded the required degree of acceptance by the industry, and is to become effective December 15, 1937. The revised recommendation will be identified as Simplified Practice Recommendation R85-37.

CCC Camp Becomes Sanatorium

» » The Veterans CCC camp at Billings, W. Va., has been turned over to the Roane County public assistance department and will be converted into a permanent emergency base tuberculosis sanatorium, with a capacity for 150 patients. It is proposed to equip the sanatorium according to modern standards and to employ a full staff of doctors and nurses.

Sanatorium Found Efficient

» » A committee comprised of well known hospital people and laymen of Cincinnati, Ohio, has made a survey of the tuberculosis sanatorium to determine if it were efficiently operated and if any economies could be effected. The committee, in its report, commended the operation of the hospital and reported that no economies of importance were possible.

Hospital Receives Bequest

» » Former Congressman Morton D. Hull, who died recently, left Provident hospital of Chicago $10,000 in his will.

Change of Ownership

» » Transfer of the South View Isolation Hospital, Milwaukee, Wis., from city to county supervision has been approved by the common council's public utilities and health committee, providing the county agrees to certain stipulations.

Practical Nurses Organize

» » A Professional Practical Nurses' Association was recently organized at Dayton, Ohio. Sylvia M. Heckman, wha has been an active nurse in Dayton for 30 years, was elected president of the organization. Other officers are: Elizabeth Scherer, vice president; Elizabeth Freeze, secretary; Emily Gieger, treasurer.

To set higher standards of service and conduct among practical nurses of this city is the aim and purpose of this association. Under these principles the organization believes that practical nurses can be better fitted to serve the public.

Doctors Build Emergency Room

» » At the Emergency Hospital, Buffalo, N. Y., physicians and surgeons of the staff recently subscribed $6,500 to provide a room for the treatment of emergency patients.

Quadruplets to Establish an Orphanage

» » It is reported that the Keyes sisters, famed quadruplets who live at Hollis, Okla., said to be the only living quadruplets to reach maturity, have decided to use their talents and abilities commercially and to devote all money derived from their efforts to the development of an orphanage at Center, Colo. The orphanage will be known as the "Golden Keyes" home. It is planned not only to take care of orphans during their childhood, but to set aside a trust fund to be paid when they arrive at their majority.

Shortage of Beds

» » From Minot, N. D., comes a report of shortage of beds. St. Joseph's Hospital of that town has found it necessary, because of lack of space in the hospital proper, to equip the second floor of the nurses' home to provide medical service for chronic patients.

Another 50th Anniversary

» » Children's Hospital, Oakland, California, recently passed its 50th anniversary. The occasion was recognized by a dinner program at the Hotel Leamington at which Senator William F. Knowland was the principal speaker.

Hospital Fire

» » At Newberry State Hospital, Newberry, Mich., a fire occurred recently involving a loss estimated at $100,000. There was no loss of life.

Ellis Hospital, Schenectady, N. Y.

» » Ellis Hospital at Schenectady, N. Y., will proceed immediately with a building and remodeling program which will increase the hospital's capacity by 100 beds and substantially improve scientific departments, as a result of the most successful fund raising campaign ever conducted in that city.

The public was asked to subscribe $700,000, the largest fund ever sought by public subscriptions in the vicinity, but when the figures were tabulated at a final report meeting of volunteer workers, the total reached $845,069. This represented the gifts of more than 23,000 persons, or the equivalent of nearly one subscriber for every family residing in Schenectady. Post-campaign subscriptions have already increased the fund to more than $850,000.

The enlarged Ellis Hospital as it will appear after adding 100 new beds and improved scientific departments. Its expansion program was assured when its $700,000 building fund campaign resulted in subscriptions amounting to $850,000.

Maternal Welfare

» » Katharine F. Lenroot, Chief of the Children's Bureau, U. S. Department of Labor, has announced that at the request of various professional groups and national organizations interested in maternal and infant health and welfare, the Children's Bureau is calling a conference on Better Care for Mothers and Babies to be held in Washington, January 17 and 18, 1938.

Recognition of Long Service

» » Charles Duchman, who has been superintendent of Memorial Hospital, Buffalo, New York, recently received tangible recognition of this long service. Mr. and Mrs. Duchman were presented with a silver service and a lamp.

Another Recognition Of Long Service

» » At Jackson Hospital, Miami, Florida, Dr. Robert C. Woodard was recently presented with four plaques in recognition of his long service as superintendent of the institution. The first plaque depicted the building in 1910; the second, that of 1917; the third, the new modern structure; the fourth plaque expressed the loyalty and cordial sentiments of the staff.

Hospital Insurance Plan In Atlanta, Georgia

» » Atlanta hospitals have been successful in having necessary legislation passed and have secured a charter for group hospitalization organization. Five of the Atlanta hospitals are participating in the plan and it is the intention to make the service available for wage earners and salaried groups in the lower categories if gainfully employed and under sixty-five years of age.

St. Joseph's Hospital, Mitchell, N. D.

» » St. Joseph's Hospital, Mitchell, S. D., under the direction of the Presentation Sisters, Aberdeen, S. D., has organized its School of Nursing for the coming year with the addition of a full time instructress of nurses. The library of the nursing school is being catalogued and a definite budget has been set aside by the school board for the purchase of reference works.

Training Center for Practical Nurses

» » The Detroit Council on Community Nursing, a Community Fund agency, has opened a new center for the training of practical nurses. This course will be supervised by a registered nurse who will be assisted by a staff from the State Vocational Administration.

N. D. Nurses Celebrate Fiftieth Anniversary

» » The North Dakota State Nurses' Association recently celebrated the 50th anniversary of its organization, at Bismarck, N. D. The guest speaker was Mrs. C. E. Platz of Atchison, Kan., who was president of the Association for four years.

Another Increase in Rate

» » The board of trustees of the Easton Hospital, Easton, Pa., has increased rates, effective November first. This was rendered necessary because of recent legislation reducing the hours of those employed in the hospital.

PERSONALS

● MISS SARAH K. RUHL, R. N., has resigned her position as superintendent of the Evangelical Deaconess Hospital, Monroe, Wis.

● CHARLES E. IRWIN, M. D., of Marshalltown, Iowa, has been appointed superintendent of the State Hospital for Epileptics to succeed A. R. Schier, M. D.

● MISS BERYL HOOVER, superintendent of the Brookville Hospital, has been appointed superintendent of the Nason Hospital at Roaring Springs, Pa.

● L. A. JOHNSON has resigned his position as superintendent of the Iowa Lutheran Hospital, Des Moines, Ia.

● MRS. MARGARET FAIR has been appointed superintendent of Alexandria Hospital, Alexandria, Va., to succeed Miss Fanny Carter who recently resigned.

● MORRIS HINENBURG, M. D., has resigned as medical director and superintendent of the Denver Sanatorium of the Jewish Consumptives' Relief Society, Spivak, Colo., to resume his former position as executive director of the Jewish Hospital of Brooklyn on December 1, 1937. Doctor Hinenburg was formerly assistant director at the Montefiore Hospital, New York, where he was associated with Doctor E. M. Bluestone for more than seven years.

● MISS EMMA KELTING has been appointed directress of the Marion Louise Withey School for Nurses at Blodgett Memorial Hospital, Grand Rapids, Mich. Miss Kelting was born in Williamsburg, Ia., received her B. A. and M. S. degrees at the University of Iowa and is a graduate of the school of nursing at Iowa.

● STEPHEN MANHEIMER, M. D., executive director of the Jewish Hospital, Brooklyn, New York, resigned from his post, effective December 1, to accept the appointment of director of Mount Sinai Hospital, Chicago. He expects to assume his new duties early in 1938.

● MISS SHIRLEY HAMRICK of Cedartown, Ga., was elected president of the Georgia State Nurses' Association at the closing session of the annual three-day convention held in Atlanta.

● MAURICE NORBY, for the past year field representative of the Minnesota Hospital Service Association, has been appointed executive secretary of the newly organized hospital service association of Pittsburgh.

● S. M. BETTINGER, M. D., formerly assistant superintendent at North Carolina Sanatorium, has been appointed assistant superintendent and medical director of the new Western North Carolina Sanatorium at Black Mountain.

● S. S. BOGLE, M. D., for twenty-six years superintendent of Sonoma County Hospital, Santa Rosa, Calif., has resigned. James G. Anderson, M. D., has been appointed to succeed him.

DEATHS

● The death of ANNA T. McCANN, office manager for the American Hospital Association, will be felt as a personal loss by a large number of those associated with hospital work. For nineteen years, Miss McCann has been connected with the Association and by her pleasant manner and general efficiency had made a host of friends both at the office and at the annual conventions. Miss McCann has not been well for several months, but continued to carry on her duties until late in October when she contracted pneumonia from which she died on Sunday, November 28.

● MRS. ANNA MARY HAYES, 66, one of the oldest graduates of the School of Nursing, Mercy Hospital, Pittsburgh, died at her home in Pittsburgh after a short illness. Mrs. Hayes was a member of the first graduating class at Mercy in 1895 and later became first superintendent of the old Pittsburgh Hospital.

PROJECTS

● Clarksville, Ark., has advertised for bids to construct the new $45,000 municipal hospital building. The structure will be two stories high, 41 feet wide and 92 feet long, with part basement.

● Application for a building permit for the erection of a seven-story $200,000 nurses' home for St. Luke's Hospital, Denver, Colo., has been filed with the building inspector.

● Establishment of a tuberculosis sanatorium in Crescent City, Calif., is the latest philanthropy of G. O. Knapp, wealthy Santa Barbara man, who presented the Knapp hospital to the city some years ago.

● Purchase of two modern fire trucks and other fire-fighting equipment at a cost of $16,000 completes a successful program to make the State Hospital at Chattahoochee, Fla., a first class fire risk.

● Governor M. Clifford Townsend recently dedicated the $200,000 Knox County Tuberculosis Hospital at Vincennes, Ind.

● The State Hospital Board of Louisiana has selected a site in Pineville for the new Central Louisiana Charity Hospital. The site is now being surveyed and plans are nearing completion. The first unit, to cost $200,000, will be three stories, 304 by 60 feet. The building will contain 240 beds, operating rooms, clinic, nurses' quarters, kitchen, etc. Edward F. Neild, City Bank Building, Shreveport is the architect.

● Lafayette Sanatorium, Lafayette, La., of which Dr. L. O. Clark is the president, has awarded a contract to J. B. Mounton, Lafayette, for constructing an addition to the sanatorium. Work is to start at once.

● The Baptist Hospital, New Orleans, La., has awarded a contract to R. P. Farnsworth & Co., for construction of nurses' building which will consist of two stories.

● The Board of Managers of the Springfield State Hospital, Sykesville, Md., have asked for bids for the construction of a new hospital and dormitory building. The total cost of the work is estimated at $345,450.

● It is announced that work will be started shortly on the construction of a $2,500,000 United States Marine Hospital at Brighton, Mass. The Government has appropriated the $2,500,000 for the construction of this new marine hospital which, when completed, will provide 300 beds.

● The Kellogg Foundation of Battle Creek, Michigan, has appropriated $75,000 for carrying on its child health program in Hillsdale county for the next 12 months. A $1,000,000 fund was created by W. K. Kellogg, noted philanthropist, when the foundation was started some years ago.

● The Ypsilanti (Ohio) State Hospital will spend one million dollars to provide four new buildings capable of housing 1,053 patients. In addition, there will be an occupational therapy building and a building to house 140 employees.

● The Iowa Methodist Hospital at Des Moines, Iowa, has undertaken a new building program; estimated costs to exceed $200,000. Among the improvements there will be included a new eight-story wing which will increase the present number of beds to 400.

● Construction work has been commenced on a new $40,000 community hospital at Tecumseh, Mich. Plans call for a brick building 75 to 80 feet, with two wards of five beds each, a children's ward of four beds, a nursery with seven bassinets, eight private rooms and completely equipped, air-conditioned operating and delivery rooms. R. E. Boyer of Ann Arbor is the architect and director of construction of the building.

● The contract for architectural work at Pontiac State Hospital, Pontiac, Mich., was awarded to Derrick & Gamber, Detroit. This is part of a two year building and maintenance program totaling $2,058,000, approved for Pontiac State Hospital by the last Legislature.

● The Sisters of Mercy from Valley City have taken over St. Anthony's Hospital, Oakes, N. D., from the Benedictine Sisters. The Benedictine Sisters will return to Winnipeg, Man., and will work with the missions and the hospitals of the order in Canada.

● On Wednesday, November 10, Governor Clyde Hoey of North Carolina formally opened the new $625,000 Western North Carolina Sanatorium on the Black Mountain highway.

● The new North Plains Hospital in Borger, Texas, opened October 29. The hospital ranks as one of the finest, most modern institutions of its kind in that section of the state.

● The new $30,000 addition to the Weakley County Hospital at Martin, Tenn., has been completed and formally opened. The hospital has served counties in West Tennessee and West Kentucky for 12 years.

● The Houston, Texas, City Council has approved plans for the construction of a new Jefferson Davis Hospital building which, it is estimated, will cost $12,000. The architect is A. C. Finn, Houston.

● Approval of the deed of conveyance for property purchased by Provo City, Utah, as a site for the proposed Utah Valley Hospital has been made by the Commonwealth fund of New York, donors of a $200,000 grant for erection of the hospital.

BOOK REVIEW

MEDICAL RECORDS IN THE HOSPITAL. Malcolm T. MacEachern, M.D., C.M., D. Sc. Cloth. 374 pages. Price $3.00. Physicians' Record Co., Chicago, Ill. 1937.

This volume is one which will fill a long felt need in the field of medical records library science. It is one which the instructors of approved schools for the training of medical records librarians may use as a basis for teaching; it may be used in the review by those record librarians preparing to take the examination for registration; and last, but by no means least, it should be a valuable addition to the library of every hospital administrator, as it will be an excellent reference book for their use and one which they may present to the members of their medical record committees and thus enlighten those members on their duties and obligations.

This valuable work begins with the evolution of the medical record, telling us that Hippocrates is credited with having written the first medical record. It cites the qualifications of the medical records librarian and acknowledges her professional status; it enumerates and explains the various methods used in securing the medical record, devoting a section to securing the record in a small hospital, a problem found especially difficult in these hospitals.

Special attention is given to the preservation of the medical record, the nomenclatures in general use today being discussed and a brief outline presented of the visible, visible loose-leaf, the loose-leaf and the card methods of indexing that may be used with any of the nomenclatures and systems. A brief resume is also presented on the punched card systems, their methods and applications.

In the discussion on the uses of the medical record, a statistical working sheet has been included which should be of assistance to the medical records librarians who are not familiar with compiling statistical analysis for their staff men. From this sheet they may learn the information necessary for such a tabulation for an analysis of Caesarean Sections and thus may draw up a similar sheet as a working basis for any other study. The addendum to this chapter cites the regulations concerning "Inspection and Transcripts of Patients Records" as formulated by St. Louis University and St. Mary's Hospital group at St. Louis. While this no doubt is not presented as a standard, it gives a knowledge of procedures in these institutions and so gives one a working basis in establishing such a procedure in their own hospital.

A chapter has been devoted to "Clinical Photography", one of the new developments that is to be associated with the medical record. Here the author states that "G. D. Carlson, M.D., Dallas, Texas, says . . . . 'if he (the physician) will employ the procedure in selected cases he will be establishing in his medical records the kind of evidence that will serve him in good stead in the face of threatening litigation' ". It will profit all medical records librarians to thoroughly read and study this chapter if this development has not already appeared in their hospital, so that they may be able to cope with the problem when it arises.

The correlation of the medical library and the medical records library is being increasingly stressed and a chapter has been devoted to this subject. By having such an arrangement any physician or group of physicians reviewing a series of cases for educational and analytical purposes may supplement this study by a review of the current literature. Various methods are discussed for the support of the medical library, one of the major problems to be considered when establishment of a library is being contemplated. Simple methods of classification are also discussed. The addendum for this chapter gives a list of textbooks and periodicals that may be used as a working basis in assembling a medical library.

This book, the first published dealing exclusively with medical records and medical records problems as a whole, is one that should especially be in the library of every medical records librarian, hospital administrator and medical record committee member. It should also be of value to department heads, giving them a knowledge of the problems encountered in an allied field, and showing them how they may give assistance in helping to solve these problems.—E.K.H.

A Once Great Hospital Regaining Prestige

» » One of our earliest recollections in the field of medical education is that of hearing Cook County Hospital, Chicago, spoken of as an educational centre in which the graduate in medicine could secure instruction in any branch. Then we began to hear criticisms from individuals and organizations interested in hospitals and medical education. These were voiced in both private and public utterances until the culmination came during the present year in the appointment of a committee, headed by Dr. Cutter of Northwestern University, to investigate and make recommendations for remedying any undesirable conditions that were found. Shortly after the appointment of this committee, Mr. Negri, an efficiency expert, was engaged to work out detail and make effective any desirable changes.

The committee severely criticized many conditions that were found to exist and recommended remedies. Mr. Negri has supported the recommendations of the committee and is gradually evolving the means whereby they can be made effective, and the Board of County Supervisors is doing its utmost to find the funds which are necessary.

If one may judge from newspaper reports and personal interviews with some of those intimately acquainted with this great hospital, many things are being done and all are in the way of improvement. Repairs to the physical plant and renovation which were reported to be so badly needed are being done; the entire purchasing system is being reorganized; the nursing staff is being materially increased. These are only a few of the improvements which are being made, but they indicate the spirit which appears to prevail.

We congratulate the Board of Supervisors, the Cutter committee and the efficiency expert on the beginning which they have made. We sincerely hope that the changes, improvements and reorganization which has been commenced will be continued until Cook County Hospital will again deserve and attain its former prestige as both an efficient hospital and a leading educational centre.

Christmas in the Hospital . . .

(Continued from page 17)

the week and on Santa's return trip to his home in the far north, he always has enough toys and boxes of candy to leave one for each child. As he reaches us on New Year's day it makes a very happy ending for the holiday season.

A Christmas Wish

I've made my wish for Christmas
I've told old Santa dear,
Of all the things I'd like to have
Including lots of cheer.

I'd really like a good strong leg
This sick one gives me pain,
Still I know 'twas sent to me
From God who sends the rain.

There's Tom who lies across from me
Why can't his arm get well?
Santa, say a prayer for him
God hears without a yell.

I want a stocking full of grit
I want some courage too,
I'd like to run and jump and play
As other children do.

I've really asked for quite a lot
Maybe too much I guess,
But God knows all that's in my heart
Each wish He seems to bless.

That's all I want for Christmas
I'm just a little chil'
If you can't bring all these things
Ask God to help me smile.

Christmas in a general hospital, as reported by F. O. Hanson, D. D., superintendent of the Swedish Hospital, Minneapolis, Minn.

Christmas begins at the Swedish Hospital about a week before December 25th. At that time forty Christmas trees arrive. A large tree is placed in each of the main lobbies of the hospital and in the parlors of the Nurses' Home. Also a tree is placed on each of the patients' floors of both hospitals. Small trees are placed on the tables in the dining room. The nurses vie with one another in decorating these trees, each floor attempting to have the prettiest Christmas tree. The office force decorates the trees in the main lobbies. In addition to this, the electrician strings lights on some of the evergreen trees growing on the lawn. He also decorates the main entrances with lights.

A Christmas party is given for the nurses of the institution on one of the evenings in that week, and another party is given for other employes on another evening of the same week. These parties are interesting and impressive events. Splendid programs are presented by each group and after the program refreshments are served. Presents are placed under the Christmas trees and distributed at these parties.

The children from a neighboring Orphan Home visit the institution on Christmas Day and sing in the lobbies, after which they are invited to breakfast in the dining room. On another morning during Christmas week, the Salvation Army Band serenades the patients, playing on the lawn outside the hospital. They too are invited to breakfast.

Choirs and other musical groups also visit the institution during this week and furnish beautiful musical numbers.

Christmas Day begins with a processional through the corridors of both hospitals. This procession assembles in the basement of the hospital. The pastor superintendent and his wife lead and are followed by the superintendent of nurses and as many of her assistants, supervisors and pupil nurses as can be present. Christmas carols are sung all the way. The procession stops on each floor while the nurses proceed—one to each patient's room door. They stand there with lighted candles while the pastor reads the Christmas message. On behalf of the management and the nurses, he extends greetings to all the patients and wishes them a blessed Christmas. The nurses also extend Christmas greetings to the patients, and return to the procession, singing carols and proceeding to the next floor. The procession finally ends in the dining room of the institution where a short devotional service is conducted for as many of the personnel as can attend, after which breakfast is served. This gives an impressive start to Christmas Day. During the day groups visit the hospital at intervals, furnishing soft and beautiful music.

The dietary department does its best to make Christmas an outstanding day. A printed menu of the Christmas dinner is handed to all patients in advance. This is a very complete turkey dinner beginning with soup and ending with nuts. All patients who can partake of this dinner appreciate it immensely. Others enjoy the decorative tray and the Christmas spirit.

In the dining room of the hospital all tables are specially decorated and a complete turkey dinner is served. All special nurses employed in the hospital or on private duty for patients are invited to dinner that day. This is appreciated by the nurses for many of them do not have their homes in the city.

Christmas at the Swedish Hospital is an enjoyable event and everything is done to make it as festive as possible for all patients and nurses who must be in the hospital over the holidays.

No special attention is paid to New Year's Day further than that special music is furnished. After New Year's Day, all decorations and Christmas trees are removed and the regular routine of the hospital is again resumed.

New York Voluntary Hospitals

Patients admitted	400,000
Full pay patients	217,000
Part pay patients	54,000
Free patients	129,000
Free dispensary visits	1,600,000
Total expenditure	$32,000,000
Income from all sources	$28,825,000
Deficit due to free work	$ 3,175,000

Dietary and Food Service

IDEAL FOOD CONVEYORS

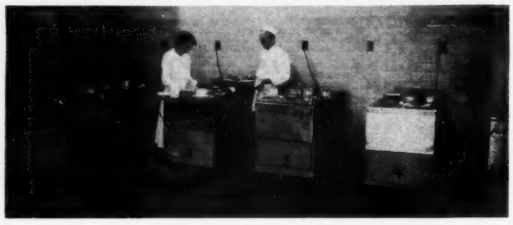
IN USE IN THE GENERAL HOSPITAL, STATE UNIVERSITY OF IOWA, GIVE

10 Years Day-in and Day-out Service

WITHOUT REQUIRING EVEN MINOR REPAIRS

Night view of the tower of the 800-bed General Hospital, State University of Iowa, Iowa City, Iowa.

Section of the large, well equipped central diet kitchen.



Partial view of the battery of 18 Ideal Food Conveyors on regular duty here at the General Hospital.

Serving 130,000 to 140,000 "kitchen-hot" meals a month—smack on the stroke of each meal time—is more than an ordinary task in this great state institution. Its 800-bed theoretical capacity (675 patients, on average, served by conveyor method) is confined to 4 floors. Horizontal distances are extensive. Yet, every patient, no matter how far situated from the central diet kitchen, receives a delicious, piping-hot meal—food kept right at the proper serving temperature, as hot as if it were served at the kitchen table. Meal service is concluded within a brief 20-minute period. The Iowa State University General Hospital uses 18 Ideal Food Conveyors. The first were installed over ten years ago. Not until recently, after 10 years constant usage, was there need on a single one of them for even minor repairs. A tribute to the built-in durability and dependability of Ideal equipment.

UNDERWRITERS' LABORATORIES APPROVAL. STAINLESS STEEL. Automatic Thermostat Control. 5-Year Electric Element Guarantee. Numerous exclusive fentures. Bulk food conveyors. Tray conveyors. Urns and coffee makers. Serving tables. Mobile cafeterias. Equipment for every institutional food service problem.

Write for free catalog

Ideal

FOOD CONVEYOR SYSTEMS

Found in Foremost Hospitals

Manufactured by

THE SWARTZBAUGH MFG. CO.

TOLEDO, OHIO, U. S. A. *Established in 1884*

Distributed by THE COLSON CORPORATION, Elyria, Ohio
Branches in Principal Cities

In Canada—The Canadian Fairbanks-Morse Co.
In California—The Colson Equipment & Supply Co., Los Angeles

DIETARY AND FOOD SERVICE

MARGARET ROSENMEIER
Dietitian, Henrotin Hospital, Chicago, Ill.
EDITORIAL DIRECTOR

CHRISTMAS RECIPES

By MARGARET ROSENMEIER
Dietitian, Henrotin Hospital, Chicago, Ill.

» » » THE CELEBRATION of Christmas is an occasion for brightness and cheer which may well be reflected in the food served to those in the hospital. The evergreen, holly, mistletoe and bright colors which prevail everywhere lend themselves admirably to both the preparation and service of the different items on the menu.

Christmas Candle Salad

½ banana per person
1 slice of pineapple per person
Section of a Brazil nut

Place the slice of pineapple on a lettuce leaf. Cut off the ends of the banana so that it stands straight. Place the banana upright in the ring of the pineapple. Place the section of the Brazil nut in the end of the candle to make the wick. When ready to serve light the nut.

Jello Chimney Salad

Arrange four square crackers or cookies in a box encircled with red ribbon. Fill the center of the box with cubed red jello and top with whipped cream dressing. Place the cracker box filled with jello upright on a lettuce leaf.

Apple and Grapefruit Star Salad

Select bright red apples for this salad. Cut the apple in slices lengthwise leaving the skin on. Section grapefruit and arrange the apple slices and the grapefruit sections alternately in a star shape on a lettuce leaf.

Holly Wreath Salad

Arrange a slice of pineapple on a lettuce leaf. Place watercress on the ring to form a wreath. Use Rubyettes or Maraschino cherries cut in small pieces to make the holly berries. Serve with mayonnaise or whipped cream dressing.

Norwegian Fruit Soup

Cook one-half cup pearl tapioca in three cups water until transparent. Add one-half cup cooked raisins, one-half cup cooked prunes, juice of one lemon and sugar to taste. Simmer over a slow fire for three or four minutes. Serve hot with sugared croutons made by glazing one-half inch cubes of bread in sugar and butter.

This may be made with any kind of fruit juices. There must be enough tapioca to make the soup slightly thick. Sugar the soup to taste. It is more appetizing if slightly tart.

Goose Stuffed with Prunes

To stuff a goose with prunes first soak the prunes overnight. Fill the bird with the uncooked prunes. Be careful not to pack the prunes in too tightly as they must be given room in which to swell. The prunes will cook while the goose is roasting and will impart a delightful flavor to the goose.

Ice Box Cookies

1 pound margarine
1½ cups white sugar
1½ cups brown sugar
3 eggs
1 tablespoon cinnamon
1 teaspoon soda
1 cup chopped almonds

Blend and knead well. Form into rolls about two inches in diameter allow to stand in the ice box overnight. Slice thin and bake.

Note: Candied cherries and pineapple in red and green colors may be substituted for the nuts for the Christmas season.

Bohemian Christmas Cookies (3 dozen)

Put the hard cooked yolks of two eggs through a ricer or sieve and cream with one-third cup of butter. Add one-third cup sugar and cream again. Stir in one uncooked egg yolk, one tablespoon milk and enough sifted flour for

(Continued on page 35)

Christmas favors and decorations used in the photographs appearing in the Food and Dietary section, courtesy The Dennison Co., Chicago.

One of the best ways to brighten up the Christmas tray is by the use of attractive, bright colored favors. These need not be expensive; all that are needed may be secured at small cost.

SPECIAL MENUS FOR THE HOLIDAY SEASON

» » » AT THE CHRISTMAS SEASON the dinner is regarded as the climax of the celebration, breakfast being light in anticipation of the noonday dinner and supper being almost superfluous. Turkey, of course, is the traditional entree for Christmas Day dinner in this country, but some still prefer the roast beef, chicken or goose of other countries, and herewith are presented four dinner menus built around these.

After the heavy dinner, the supper should be particularly dainty to tempt the appetite which has not yet recovered from the noon dinner.

Christmas Eve Supper:

Oyster Stew Crackers
Broiled Ham Candied Sweet Potatoes
Cauliflower with Pimiento Cheese Sauce
Mixed Greens and Pimento Salad
Fruit Cake

Norwegian Fruit Soup with Sugared Croutons
Creamed Mushrooms on Toast Fresh Peas
Radish Roses and Celery Hearts
Mince Meat Cookies

Tomato Juice Cocktail
Chicken a la King in Pattie Shells
Jello Chimney Salad
Angel Food Cake with Strawberry Whipped Cream

Christmas Day Dinner:

Pineapple Juice with Strawberry Ice Cocktail
Roast Goose Stuffed with Prunes Mashed Potatoes
Broccoli with Hollandaise Sauce
Molded Cranberry Salad
English Plum Pudding with Hard Sauce

Fresh Shrimp Cocktail
Roast Turkey with Chestnut Dressing Mashed Potatoes
Candied Sweet Potatoes Creamed Brussel Sprouts
Cranberry Jelly
Apple and Grapefruit Star Salad
Biscuit Tortoni Cookies
Nuts Peppermints

Sauerkraut and Tomato Juice Cocktail
Roast Beef, Yorkshire Pudding Brabant Potatoes
Sautéed Corn with Pimiento and Green Peppers
Holly Wreath Salad
Lady Baltimore Cake with Candied Fruit Decorations

Cranberry Juice Cocktail
Roast Chicken with Oyster Dressing Mashed Potatoes
Fresh Peas with Onions
Hot Rolls Currant Jelly
Frozen Fruit Salad Individual Mince Pie

Christmas Night Supper:

Cream of Fresh Mushroom Soup
Assorted Cold Meat and Cheese Plate Spiced Peaches
Hot Sandwich Rolls
Chocolate Cake with Peppermint Icing

Ham Loaf Stuffed Baked Potato
Individual Molded Cheese Ring with Green Salad
Assorted Christmas Cookies

Cold Sliced Chicken Sweet Potato Pie
Tomato Aspic and Endive Salad
Fruit Cake (light and dark)

Christmas Recipes . . .

(Continued from page 33)

rolling. Cut into rounds. Brush with beaten egg white and sprinkle with almonds chopped fine. Bake in a slow oven.

Spritz Cookies (3 dozen)

½ pound butter
2/3 cup sugar
yolks of 3 eggs
4 grated bitter almonds
2½ cups flour
½ teaspoon baking powder
Salt

Blend and put through a cookie gun.

Orange Honey Bread

2 tablespoons shortening
1 cup honey
1 well beaten egg
1½ tablespoons grated orange rind
2½ cups flour
2½ teaspoons baking powder
½ teaspoon soda
½ teaspoon salt
¾ cup orange juice
2 tablespoons orange marmalade

Cream shortening and honey. Add the beaten egg and grated orange rind and the dry ingredients. Add the orange juice and marmalade and bake in a loaf pan at 325 degrees for about an hour.

Prune Bread — Graham

1 cup prunes
1 quart whole wheat flour
1 pint graham flour
1 teaspoon salt
1 tablespoon sugar
2 yeast cakes
½ cup lukewarm water for the yeast
2 cups scalded milk or 1 cup milk and 1 cup water
1 tablespoon shortening.

Soak the prunes overnight, stone and chop fine. Mix the prunes, flour, salt and sugar together. Add the yeast dissolved in water; add the melted shortening, milk and water to make a soft dough. Allow to rise and when light stir briskly and pour into buttered bread pan. Allow to rise again and bake in a moderate oven.

Peach Bran Bread

1 cup dried peaches
Boiling water
3 tablespoons shortening
1/3 cup granulated sugar
1 egg well beaten
1¼ cups thick sour milk
½ teaspoon soda
2 cups flour
2 teaspoons baking powder
½ teaspoon salt
¼ teaspoon mace or nutmeg
1 cup whole or bran flakes
½ cup chopped nuts.

Cover the dried peaches with boiling water. Let stand for ten minutes, drain and cut into coarse pieces. Cream the shortening and sugar and add the egg, peaches and sour milk. Add the rest of the ingredients and bake in a moderate oven about an hour.

MEET the Maid from Sextontown
Whose charming smile melts every frown
In natty apron, dapper cap,
She speeds our specials o'er the map

This spritely aid to finer meals
Bespeaks the friendliness she feels
So welcome her—if but half way
You'll find your interest she'll repay

Profit, and pleasure too, she'll bring
And something new, that's just the thing
She travels far, both East and West
Always bringing just the best.

Behind her message of good will
Lie fifty years of service skill
So look for the maid from Sextontown
And serve your guests food of renown.

JOHN SEXTON & CO., CHICAGO—BROOKLYN

SEXTON QUALITY FOODS

Santa Claus and the Christmas Season

» » Centuries ago in the city of Patara in Lycia, Asia Minor, lived a kindly and much beloved man whose only joy was to bestow gifts upon the needy. He became known as St. Nicholas, and in the years to come he became a patron saint for his kindliness. As the centuries passed, the celebration of his day gradually became merged with Christmas. Just as this kindly old man made his visits during the night because he did not want praise, so the St. Nicholas of the Christmas time makes his calls in the night.

Each nation has its St. Nicholas: Germany has Kris Kringle; France, Pere Noel; Holland, Santa Claus; Russia, St. Nicholas. But whether he be St. Nicholas, Kris Kringle or Santa Claus, he still remains the same jolly person beloved by young and old, sick or well, and his day is a day of celebration. In the hospital, commemoration of his day is shown by special favors, food and decorations.

Liquid Junket Rennet Extract

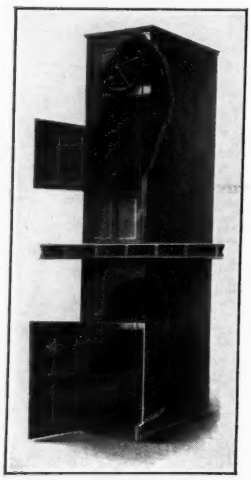
» » The Junket Company has a liquid "Junket" rennet extract. The extract comes in four natural flavors and also as an unflavored extract. Junket dessert is made by merely adding the extract to luke warm milk. Sugar is added afterwards. Because the sugar is not included in the extract, this dessert can be used on low-sugar diets.

Sedgwick HOSPITAL ELEVATOR

A Safe, Efficient, Low Cost Service

for

SMALLER HOSPITALS, SANITARIUMS, CLINICS and INFIRMARIES



This thorough dependable Elevator has been specially designed for the needs of smaller institutions. Wherever it is in use it is giving commendable satisfaction. The initial cost is comparatively low and there is no operating expense. Car sizes vary to meet specific conditions.

* * *

Sedgwick also provides a full line of electric and hand power Dumb Waiters, Laundry Lifts and other between-floor equipment for hospital use, all backed by 44 years of specialized manufacturing experience. Write for catalog.

SEDGWICK MACHINE WORKS
165 West 15th St., New York

Please send catalog. I am interested in
☐ Electric Dumb Waiters ☐ Hospital
☐ Hand Power Dumb Waiters Elevators

Name.....

Address.....

City.....State.....

Food Prices Show Slight Decrease

» » October food purchase prices decreased 1.29 per cent as compared with September, 1937, price levels, according to the latest Grinstead Food Price Index, compiled monthly by R. M. Grinstead & Company, Inc., New York City. The October index was 127.77 as compared with 118.14 in October of a year ago, being an increase of 8.15 per cent this October over last October.

All food groups except poultry and dairy products, decreased from September levels. However, all groups except vegetables and dairy products are still considerably above October, 1936, levels. While meats decreased 2.42 per cent in October, they are 23.61 per cent above last October's Index. Poultry increased 3.47 per cent this month and is now at the highest point since the Index was started in January 1934. Fish and seafood decreased 1.56 per cent from September but remains .54 per cent above October, 1936. Vegetable costs were at low point this month, being 10.09 per cent under a year ago. Salads, fruits and groceries are all above last October, while dairy products are 7.03 per cent lower despite an increase of 1.26 per cent this month.

Evaluating the weighted average of food prices paid in January, 1934 at 100, the course of price changes has been as follows:

January, 1934	100.00
October	118.14
November	117.82
December	118.15
January, 1937	122.12
February	121.63
March	123.89
April	122.44
May	121.04
June	120.77
July	124.61
August	124.71
September	129.44
October	127.77

The following table shows in percentages, the average change in October from the preceding month and from October, 1936. The proportion of the main food groups purchased last month is shown in percentages of expenditures.

Prices paid in October, 1937, compared to:

	Sept. 1937	Oct. 1936	October, 1937 Percentages of Expenditures
Meat	— 2.42%	+23.61%	27.11%
Poultry	+ 3.47	+ 8.83	12.57
Fish	— 1.56	+ .54	8.92
Vegetables	—11.33	—10.09	5.56
Salads	— 2.10	+ 5.65	2.22
Fruit	— 5.85	+ 6.96	4.77
Dairy Products	+ 1.26	— 7.03	23.36
Groceries	— .99	+ .59	15.49
Change on Total (Weighted)	— 1.29%	+ 8.15%	100.00%

Keep track of price changes by watching this Index, which appears every month exclusively in HOSPITAL MANAGEMENT.

GENERAL MENUS -- JANUARY

Suitable for Staff, Personnel and Patients Not Requiring Special Diets

Breakfast	Dinner	Supper
	Saturday, January 1	
	Cranberry Juice Cocktail	
	Roast Chicken with Pecan Dressing	Oyster Stew
Sliced Oranges	Mashed Potatoes Cauliflower	Assorted Sandwiches
Oatmeal Bacon Eggs	Frozen Fruit Salad	Fruit Salad
Toast	Plum Pudding with Hard Sauce	Baked Custard
	Sunday, January 2	
Prunes	Roast Beef Browned Potatoes	Welsh Rarebit on Toast
Ralstons Bacon Eggs	Baked Squash Watercress Salad	Baked Potato Cooked Vegetable Salad
Toast	Chocolate Marshmallow Ice Cream	Royal Ann Cherries
	Monday, January 3	
Grapefruit Juice	Broiled English Mutton Chops	Vegetable Plate Devilled Egg Salad
Maltex Cereal Bacon Eggs	Parsley Potatoes Brussels Sprouts	Rice Croquettes with Jelly
Toast	Apricot Salad Maple Nut Mold	Baked Apple
	Tuesday, January 4	
		Escalloped Chicken and Noodles
Orange Juice	Veal Birds Mashed Potatoes	Baked Hubbard Squash
Farina Bacon Eggs	Stewed Tomatoes & Celery Head Lettuce	Pineapple and Cherry Salad
Toast	Bread Pudding with Caramel Sauce	Raggedy Ann Peaches
	Wednesday, January 5	
Half Grapefruit	Baked Ham Whipped Sweet Potatoes	Scrambled Eggs and Brains
Pettijohns Bacon Eggs	Creamed Peas Apple and Date Salad	Stuffed Baked Potato Asparagus Salad
Toast	Orange Ice Sand Tarts	Fruit Cup Cocoanut Macaroons
	Thursday, January 6	
		Creamed Chicken Livers & Mushrooms on Toast
Sliced Bananas	Swiss Steak Steamed Rice	
Cornflakes Bacon Eggs	Buttered Green Beans Cole Slaw	Baked Potato Macedoine Salad
Toast	Cherry Blanc Mange	Peach Melba
	Friday, January 7	
Tomato Juice	Poached Halibut Mashed Potatoes	Cheese Fondue Fresh Lima Beans
Mapyl Cereal Bacon Eggs	Harvard Beets Celery Hearts and Olives	Spiced Prune Salad Lemon Ice
Toast	Prune Whip with Custard Sauce	Angel Food Cake
	Saturday, January 8	
Orange Halves	Meat Loaf with Mushroom Gravy	Canadian Bacon and Fried Apples
Oatmeal Bacon Eggs	Buttered Noodles Fresh Peas & Onions	Baked Potato Fresh Vegetable Salad
Toast	Molded Cranberry Salad Date Torte	Fruit Ambrosia
	Sunday, January 9	
Apricots	Fricasse of Chicken Candied Sweet Potatoes	Cream of Mushroom Soup
Omar Cereal Bacon Eggs	Asparagus Stuffed Prune Salad	Fruit Salad and Cheese Plate
Toast	Peppermint Ice Cream	Chocolate Brownies
	Monday, January 10	
Apple Sauce	Baked Tenderloin French Fried Potatoes	Scrambled Eggs and Ham
Ralstons Bacon Eggs	Peas Grapefruit Salad	on Toasted English Muffins
Toast	Cottage Pudding with Chocolate Sauce	Head Lettuce Fruit Jello
	Tuesday, January 11	
Prune Juice	Leg of Lamb Mashed Potatoes	Spaghetti with Meat Balls
Wheatena Bacon Eggs	Minted Carrots Pear, Cottage Cheese Salad	Stuffed Celery Hearts
Toast	Pumpkin Custard	Fruit Compote Sugar Cookies
	Wednesday, January 12	
		Broiled Sweetbreads and Mushrooms on
Peaches	Roast Veal Mashed Potatoes	Skewers Stuffed Baked Potatoes
Cream of Wheat Bacon Eggs	Cauliflower Sliced Orange Salad	Cooked Vegetable Salad
Toast	Date Nut Blanc Mange	Raspberry Ice Vanilla Wafers
	Thursday, January 13	
Raspberries	Pot Roast of Beef Steamed Potatoes	Chicken a la King on Holland Rusk
Shredded Wheat Bacon Eggs	Buttered Onions Pickled Beet Salad	Escalloped Corn Vegetable Salad
Toast	Glorified Rice Pudding	Seedless Grapes
	Friday, January 14	
	Broiled Cod with Egg Sauce	
Pineapple Juice	Buttered Hominy Broiled Tomatoes	Jelly Omelet Creamed Potatoes
Pettijohns Bacon Eggs	Raw Vegetables in Gelatin	Head Lettuce, Russian Dressing
Toast	Peach Cobbler	Sliced Oranges and Bananas
	Saturday, January 15	
Figs	Fricasse of Veal Whipped Potatoes	Creamed Macaroni and Chipped Beef
Oatmeal Bacon Eggs	String Beans Waldorf Salad	Wilted Lettuce
Toast	Chocolate Angel Food Cake	Snow Pudding with Custard Sauce

HOSPITAL MANAGEMENT'S DIETARY AND FOOD SERVICE DEPARTMENT

GENERAL MENUS FOR JANUARY

Continued

Breakfast	Dinner	Supper
Sunday, January 16		
Half Grapefruit Ralstons Bacon Eggs Toast	Chicken a la Maryland Parsley Potatoes Spinach with Lemon Frozen Fruit Salad Macarron Ice Cream	Carrot Loaf with Fresh Peas Baked Potato Head Lettuce Salad Black Cherries
Monday, January 17		
Sliced Bananas Cream of Wheat Bacon Eggs Toast	Stuffed Breast of Veal Mashed Potatoes Mashed Squash Mixed Fruit Salad Spanish Cream	Fresh Asparagus on Toast, Cream Sauce Baked Potato Cottage Cheese Salad Orange Bread with Marmalade
Tuesday, January 18		
Apricots Farina Bacon Eggs Toast	Roast Beef Browned Potatoes Fresh Lima Beans Pineapple Tid Bit Salad Caramel Bavarian Cream	Broiled Mushrooms on Toast Stuffed Sweet Potatoes Cauliflower Salad Apricot Whip
Wednesday, January 19		
Canned Plums Puffed Rice Bacon Eggs Toast	Lamb Patties Creamed Potatoes Buttered Beets Celery Hearts, Olives Strawberry Ice Cream	Individual Meat Pie with Vegetables Fruit Salad Devils Food Cake, Fudge Icing
Thursday, January 20		
Pears Wheatena Bacon Eggs Toast	Broiled Liver & Bacon Noodles au Gratin Julienne Carrots Fresh Fruit Salad Cherry Tarts	Chop Suey on Chinese Noodles Head Lettuce Salad Steamed Rice Walnut Slices
Friday, January 21		
Prune Juice Cream of Rye Bacon Eggs Toast	Broiled Salmon with Lemon Succotash Parsley Potatoes Peach Salad Graham Cracker Pudding	Fried Scallops with Tartar Sauce Baked Potato Vegetable Salad Cream Cheese, Jelly and Crackers
Saturday, January 22		
Canned Grapefruit Cornmeal Bacon Eggs Toast	City Drumsticks Mashed Potatoes Stewed Tomatoes Water Cress Salad Steamed Pudding with Vanilla Sauce	Pork Sausage Patties Apple Rings Candied Sweet Potatoes Celery Hearts, Carrots Floating Island
Sunday, January 23		
Orange Halves Wheaties Bacon Eggs Toast	Baked Chicken, Dressing Riced Potatoes String Beans Cranberry Relish Salad Black Walnut Ice Cream	Cold Meat, Potato Salad Plate Fresh Vegetable Salad Fruit Cup Filled Cookies
Monday, January 24		
Applesauce Ralstons Bacon Eggs Toast	Swiss Steak Steamed Potatoes Creamed Celery Stuffed Fig Salad Lemon Cream Pudding	Individual Baked Squash Stuffed with Potatoes Buttered Peas Rice Pudding with Raspberry Sauce
Tuesday, January 25		
Peaches Cream of Rice Bacon Eggs Toast	Broiled Lamb Chops Parsley Potatoes Mint Jelly Prune Salad Spinach with Hard Cooked Egg Cocoanut Bavarian Cream	Manhattan Meat Roll, Vegetable Gravy Fruit Salad Sponge Cake
Wednesday, January 26		
White Cherries Rice Crispies Bacon Eggs Toast	Broiled Ham Mashed Potatoes 7-Minute Cabbage Cinnamon Apple Salad Tapioca Cream Pudding	Sauteed Chicken Livers Buttered Noodles String Bean Salad Stuffed Baked Apple
Thursday, January 27		
Tomato Juice Cream of Wheat Bacon Eggs Toast	Short Ribs of Beef Grilled Vegetables Green Salad Banana Pudding	Macaroni and Cheese Spiced Fruit Vegetable Salad Pineapple Ice Wafers
Friday, January 28		
Prunes Pettijohns Bacon Eggs Toast	Broiled White Fish with Tartar Sauce Shoestring Potatoes Escalloped Eggplant Head Lettuce Salad Apricot Upsidedown Cake, Whipped Cream	Shrimp a la Newburg Baked Potato Tomato Salad Chocolate Pudding
Saturday, January 29		
Stewed Raisins Oatmeal Bacon Eggs Toast	Lamb Steak Franconia Potatoes Diced Turnips Peas in Lemon Jello Salad Angel Food Cake with Fruit Sauce	Vegetable Plate: Spinach with Poached Egg, Harvard Beets, Steamed Rice Kidney Bean Salad Ambrosia, Wafers
Sunday, January 30		
Canned Apricots Omar Cereal Bacon Eggs Toast	Turkey a la King in Pattie Shells Mashed Potato Brussel Sprouts Fresh Fruit Salad Vanilla Ice Cream	Cream of Corn Soup Toasted Tomato and Bacon Sandwich Celery Hearts, Radishes Lady Baltimore Cake
Monday, January 31		
Sectional Grapefruit Maltex Cereal Bacon Eggs Toast	Roast Beef Boiled Potatoes Cauliflower Polonaise Chopped Vegetable Salad Norwegian Prune Pudding	Hot Chicken Sandwich Mashed Potatoes Cole Slaw Home Style Pineapple

Department of Nursing Service

MODERN *Surgical Illumination*

AMERICAN LUMINAIRE *Surgical Light*

CLOSE analysis of the problems involved in surgical illumination clearly indicates that—the ultimate is approached when design and construction cater altogether to the "comfort of the surgeon," to the end that he is enabled to do his delicate and exacting work, without being conscious either of the illumination or its source.

Further analysis from this angle defines that the light shall be of the right intensity (foot candles)—not too great nor too weak—so that there is clear visibility; that the light shall be of a color quality (color temperature—degrees Kelvin) that permits clear discrimination of objects in their natural color; that the light be so distributed that shadows are reduced to a minimum (light projection); and finally that these specifications be met—developing a negligible quantity of heat in the surgical area (a detail of light filtration).

★ ★

SEND FOR AMERICAN LUMINAIRE SURGICAL LIGHT—BULLETIN L

A Few Prominent Users

Kern County General Hospital (2 units)	Bakersfield, Calif.
Samuel Merritt Hospital (2 units)	Oakland, Calif.
St. Joseph's Hospital (5 units)	Denver, Colo.
Pensacola Hospital (2 units)	Pensacola, Florida
American Hospital (2 units)	Chicago, Ill.
Beth Israel Hospital	Boston, Mass.
St. Vincent's Hospital (3 units)	Worcester, Mass.
St. Joseph's Mercy Hospital (4 units)	Detroit, Mich.
Midway Hospital (8 units)	St. Paul, Minn.
Mounds Park Sanitarium (6 units)	St. Paul, Minn.
Hudson County T. B. Hospital	Jersey City, N. J.
Carrie Tingley Hospital (2 units)	Hot Springs, N. M.
Crile Clinic (2 units)	Cleveland, Ohio
Temple University Hospital (3 units)	Philadelphia, Pa.
St. Francis Hospital	Pittsburgh, Pa.
Baptist Memorial Hospital (6 units)	Memphis, Tenn.
Southwestern General Hospital (4 units)	El Paso, Texas
Hermann Hospital (4 units)	Houston, Texas
Jefferson Davis Hospital (27 units)	Houston, Texas
Tacoma General Hospital	Tacoma, Wash.

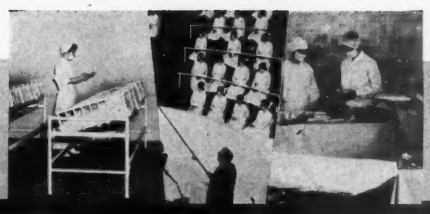
AMERICAN STERILIZER COMPANY

ERIE, PENNSYLVANIA

Sales Offices in New York, Chicago, Boston, St. Louis
Agencies in Principal Cities in the United States

Represented in Canada by Messrs. Ingram and Bell, Ltd., Toronto, Montreal, Winnipeg, Calgary

APPROVED AMERICAN COLLEGE OF SURGEONS



DEPARTMENT OF NURSING SERVICE

JANET FENIMORE KORNGOLD
Director, School of Nursing, St. Luke's Hospital, Chicago, Ill.
EDITORIAL DIRECTOR

FINANCIAL DEMANDS OF THE NEW CURRICULUM ON THE SCHOOL OF NURSING

By MRS. JOYCE KNUDTSON KUHN, R. N.
Director of Nurses, Rockford Hospital, Rockford, Ill.

» » » NEW PROGRAMS in nursing education always meet obstacles of many kinds; most of these can be traced to financial difficulties. One of the biggest questions raised about the operation of the "new curriculum" has to do with how to secure funds to make possible its inauguration. The cost of conducting a school after the design of the "new curriculum" will depend a good deal on the adjustment of the program to the peculiarities of the particular institution and on the nursing facilities of each school.

The schools which are following the recommendations of the 1927 curriculum will perhaps have less difficulty in adjusting, especially if they charge tuition fees for the early part of the program, when students have fewer hours on the ward during the day, week or year.

If this estimate of increased cost is based on actual educational services, equipment, etc., the difference of operating in 1927 or 1937 will not be so great. Probably the main cost to the hospital will be for providing nursing service to take the place of the students, who under this plan will give fewer hours of work in the wards. For example: an eight-hour day will include class work as well as ward work.

Various estimates have been made of the cost of instruction and maintenance of student nurses. It is usually conceded to approximate $800.00 a year, and we will use this figure in our comparative study of costs under the "old curriculum" and the "new."

Nursing service has definite cash value to the hospital, and this value should be credited to the nurse who renders the service, even when she be a student. Studies have been made resulting in the opinion that the services of a first year student may be considered worth 25c per hour; of the second year student, 35c per hour; and of a third year student, 40c per hour. Operating under the "new curriculum", during the first four months the student would give no service. In the second four months she would spend an average of eighteen hours per week in the hospital and her service would be worth $4.50 per week. The third four months she would average twenty-two hours per week, representing a value of $5.50 a week. Thus in her first year she would render service to the value of $160.00. With the student's cost to the institution figured at $800.00, she would owe the hospital $640.00 at the end of her first year.

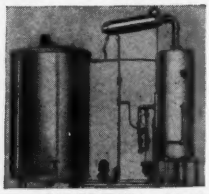
In the second year, a maximum of thirty-eight hours per week would be spent in the ward. At 35c per hour her services would be worth $13.30 per week or $638.40 per year. With the institutional cost estimated at $800.00, she would owe the hospital $161.60 for her second year course.

In the third year a maximum of thirty-eight hours per week would also be spent in ward service. Figured at 40c per hour, the senior student's labor would represent $15.20 per week or $729.60 for the year, leaving her in debt to the hospital to the amount of $70.40 for her third year. The student's total cost to the hospital—$2,400 for the three year course—would be partly offset by the value of the student's labor, amounting to $1,528.00, leaving a balance of $872.00 due to the hospital. It is frequently suggested, that in fairness to hospitals, this sum should be paid, either by the nurse, by income from endowments, by donations or from other sources.

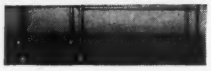
Operating under the 1927 curriculum, the nurses give forty-eight hours of service per week in second and third terms. On this basis, her cash value at 25c per hour would amount to $384 in the first year and she would owe the hospital $416 at the conclusion of the year. In her second year—forty-eight hours per week at 35c per hour —her services would be worth $806.40 and she would be entitled to a credit of $6.40. In the third year her labor would be worth $921.60 and she would be entitled to a credit of $121.60. Thus with the "old curriculum,"

The photograph on the departmental frontispiece is from the film "Standard Obstetrical Routine", and is used by the courtesy of The Mennen Company.

WATER YOU NEED



WHERE AND WHEN YOU NEED IT



You get more from Barnstead Water Stills than chemically and bacteriologically pure water. You get convenience. Barnstead Stills can be installed where you want them and how you want them. They are furnished for mountings on tables, shelves, walls or mounted complete on a stand. Furthermore, they can be installed behind a wall with only the controls and faucets showing.

Completely automatic in every respect Barnstead Stills furnish you with a constant supply of freshly distilled water —always pure, always ready, always safe. And because of their perfect fitness for hospital use thousands are installed in institutions the world over.

There are Barnstead single, double, and triple stills. Stills operated by gas, steam, electricity or kerosene. Sizes from ½ gallon per hour up. Send for new catalog.

Barnstead
STILL & STERILIZER CO. Inc.

25 LANESVILLE TERRACE, FOREST HILLS, BOSTON, MASS.

MENNEN
Antiseptic
OIL

has been adopted for routine nursery use by 2825 hospitals to date*

*DECEMBER 1, 1937

Are Your Department Heads receiving copies of HOSPITAL MANAGEMENT? You should see to it that they are, for each issue contains much of value to them that will be reflected in the smoother, better functioning of their department when the ideas each issue brings are put into practice. Suggest to them that they subscribe today. $2.00 a year, or two years for $3.00.

HOSPITAL MANAGEMENT
612 North Michigan Avenue • Chicago, Illinois

the cost of the student's preparation to the hospital—$2,400—is offset by the value of her services to the amount of $2,112.00, leaving a balance due to the hospital for the entire course, of $288.00.

As a matter of fact, the "new curriculum" does not increase very considerably the total number of hours of instruction. Undoubtedly many schools could bring their class schedules up to the requirements of the "new curriculum" with no increase in the number of their faculty members. The slight addition to the teaching load in those schools already meeting the requirements of the 1927 curriculum could, in most cases, be borne by the present faculty plus additional service from supervisors and head nurses. The increased cost for instruction under the new regime will hardly result from increased teaching hours; it will result from the decrease in the number of hours of bedside service contributed by student nurses.

In schools already meeting the standards of the previous curriculum, the financial outlay for teaching space and teaching equipment will not produce a crisis. However, there are very few schools meeting the standards of either the 1927 or 1937 curriculum in regard to library facilities. To develop libraries worthy of real educational institutions will require considerable expenditure.

However, the significant increase in the cost of school operation will result from the necessity of increasing the size of the general duty nursing staff. Such an increase is desirable at this time in the overwhelming majority of hospitals maintaining schools of nursing. Not only are additional graduate nurses needed to supply bedside care as a result of the reduction in the ward-hours of the student nurse, but increasing demands for affiliated courses in the nursing of contagious diseases, the nursing of mental and nervous diseases, and in public health nursing still further deplete the student body available for bedside care in the hospital, thus increasing the demand for a larger graduate staff.

Problems of financing a school of nursing are much more complicated than those found in educational institutions of other types, because of the difficulty in separating the cost of education from the cost of operating the nursing service of the hospital. A good school of nursing should have financial resources adequate to advance its educational program on a high professional level. A school of nursing, like any other professional school, needs to be assured of an adequate and stable income. It is now clear to most people interested in the problem, that the school of nursing should have a budget distinct and separate from the general budget of the hospital with which it is connected.

To be sure, we are only at the threshold of the era of independent incomes for schools of nursing. The pinched budget of practically all of our schools and the unstable financial basis on which they operate is largely due to the fact that through all these years the school has usually been an integral part of the hospital in which it is operated and has been unconsciously, if not consciously, regarded as an asset to the hospital, in that the labor of its student body obviated the payment of cash wages to the nursing personnel.

If the ordinary revenue of the hospital is to remain the outstanding source of income for the school of nursing, there is little assurance that an excellent program of

education can be maintained. This is a misfortune, as a good educational program is only possible when reasonable provision can be made for stability, not only for a year or so, but over a long period of years, in order that a definite educational program can be carried out.

A good school of nursing requires an income from endowment, but as yet only a few schools are thus highly favored. Likewise, a few schools are the recipients of definite gifts, because contributors have recognized the hospital both as an educational institution and as an agency supplying nursing service. It is becoming more and more usual for a donor to indicate what portion of his contribution is to remain in the hospital and what part is to be applied definitely to the needs of the school.

It is quite apparent that tuition fees also constitute a possible source of income to schools of nursing. At the present time these fees are usually quite nominal, covering only the cost of uniforms, textbooks, physical examinations, etc. It is true that there is no reason why the student nurse should not pay for an education which prepares her to practice a profession. The custom has been for the student to pay the entire cost of her education and maintenance by her labor. If this system is to be discarded it is apparent that schools will have to offer a much higher type of instruction and a better organized educational program than they are offering at present, if students are to be expected to make a heavy cash payment for it. The nursing world is abandoning the idea that the only possible way of financing the educational program is through the value of the nursing service rendered to the hospital by students. While these services should be considered in estimating the costs, and a much better method worked out for arriving at an estimate of their value, other means should be found for covering some of the costs of education. But if the student is to pay $800 or $1,000 for her nursing education, it will of necessity have to be an excellent program that is presented to her.

It is quite likely that in a not too far distant future nursing education will receive considerably more support from public funds. In the past we have rarely received such assistance save when the school forms a part of a tax supported university or college. It is assumed that educational institutions which prepare workers for necessary forms of public service such as teaching, engineering, medicine, etc., should receive assistance from public funds. Nursing schools are certainly also justified in asking for public support on the basis of the public service which they render. Propaganda must be carried on until public authorities become convinced that such funds will be used for truly educational purposes and that the institutions receiving them are operating on a sound educational basis. The general public must be enlightened as to the actual cost of the nursing care of patients in hospitals, and also as to the cost of nursing education. Hospitals cannot and should not be expected to meet all the expense of the program of nursing education. The "new curriculum" points the way by which schools of nursing may become truly educational institutions. It presents a standard by which we can measure the achievements to which our schools have attained at present and it presents an ideal toward which we must constantly build.

Presented at the Annual Convention of the Illinois State Nurses' Association, Springfield, Illinois, October 21-24, 1937.

MEDICAL AUTHORITIES SAY:

"O.K." TO IVORY

IT'S PURE!

IT'S WHITE!

IT'S UNPERFUMED!

Countless tests have proved Ivory to be an unusually safe soap for both adult and baby skin.

And logically so. For Ivory is superbly pure. It contains no harmful ingredients . . . no irritating free alkali . . . no free fatty acid . . . no artificial coloring . . . no perfume.

Ivory is today the preferred soap in the big majority of American hospitals. Why not let this pure soap assume the responsibility of assuring safe, gentle cleansing for **your** patients?

PROCTER & GAMBLE
Cincinnati, Ohio

IVORY SOAP ★

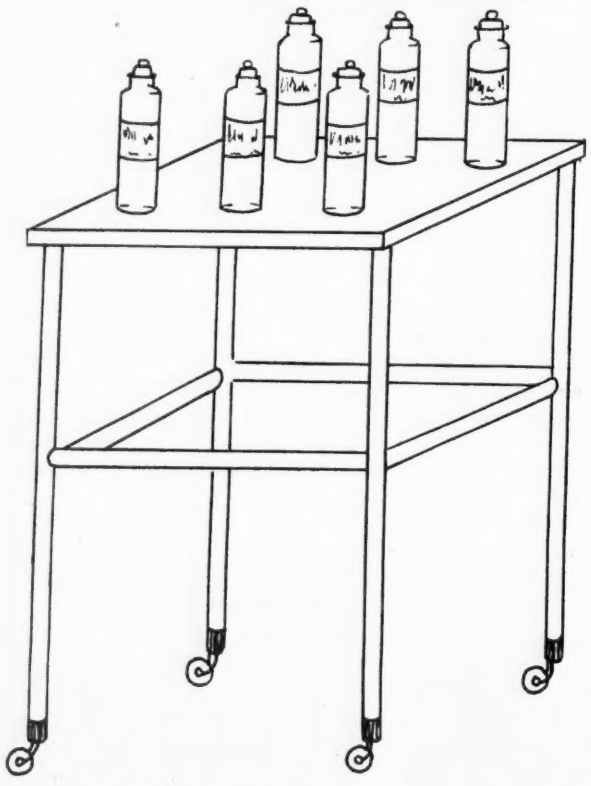
In addition to the familiar medium and large sizes for general cleansing, Ivory Soap comes in a choice of six convenient, economical, miniature sizes especially suitable for hospital use. Cakes weighing from ½ ounce to 3 ounces — either wrapped or unwrapped — are available for both patient and personnel.

CONSIDERATIONS ON INSTRUCTION IN CHEMISTRY

By BESSIE BROOKS COLOMB, R.N., A.B.
New Orleans, La.

» » » IN PREPARING to present a course in chemistry to student nurses, the first question arising in the instructor's mind is, probably: will the content of the course be based on certain applications of chemistry or shall the course be "general chemistry"—as much of it as can be presented in the time allotted to the course. The instructor may answer the question with greater ease, and perhaps greater justice to the student, by consulting a series of the past state board examinations in the state in question. The attitude of the state examiner in chemistry is certainly not to be ignored.

The instructor's outline for the course in chemistry, in fairness to the students, should have the same general objective as that of the state board examiner. If the state examination has covered "general chemistry," that is, the subject matter of the usual high school chemistry course, and the instructor in the school of nursing has confined her subject matter to certain applications of chemical theory which appear to her to be most valuable to the nurse, the students may fail on the state board examination, because in the limited number of hours allotted to the subject they have failed to (1) work chemical arithmetic, (2) derive structural formulae, (3) balance equations properly, (4) write numerous symbols and formulae, (5) explain the principal points of the various chemical theories, (6) dissertate on the several chemical laws.



THE MOVABLE REAGENT TABLE SAVES TIME AND ENERGY

Certain it is that many instructors in chemistry in schools of nursing are obliged to approach their work from two angles—first, the presentation of material which will have a definite value to the nurse as a nurse, and second, the presentation of material that has definite examination-passing possibilities. Unfortunately, there are still many states in which the objective of the state examiners has not been made clear to the instructors in the schools; and, certainly, a definite understanding between the schools and the examiners is necessary before instruction in chemistry can be greatly improved.

But the objective of the state board examiner is seldom the only factor in determining the content of the course in chemistry. Instructors, individually and collectively, should concern themselves with the consideration as to what things which could be taught in a chemistry course for nurses really have a vital import in actual nursing practice. One of two things must happen in regard to the content of chemistry courses: either the elimination of useless material from limited courses or the elimination of limited courses.

The number of students entering training schools with a course in general chemistry already to their credit has greatly increased in the last five years. High school chemistry has become a requirement for entrance in many of our schools. The value of chemistry as an entrance requirement can certainly still be debated. The fact that the student has had chemistry in high school may simplify the work of the chemistry instructor in the school of nursing, but whether the possession of a high school credit in chemistry is a sound factor to use as a basis in the choice or elimination of students is questionable. A young woman who has had chemistry in high school does not become, as a result of that fact, any better material for nursing work.

Other questions arise in the mind of the serious instructor: if the content of the chemistry course in the school of nursing is to be "general chemistry," then it would appear unreasonable to have these students with high school credit retake it. It may be said that they have forgotten it, but it is quite apparent that they have forgotten even more of their arithmetic and spelling. The school of nursing cannot devote much time to the review of high school courses, since the time allotted to the real business of the nursing curriculum is all too short.

One feels that it is the application of the content of the course in chemistry that really counts, and if we devote much time to "general chemistry" we have not enough left for the application. And since it is possible

in fifteen, thirty or forty-five class hours to present material of real importance in nursing which has a foundation in chemical laws, without a build-up of "general chemistry," why is it absolutely necessary that "general chemistry" become a prerequisite for entrance to a school of nursing? As a matter of fact, in actual practice it is observed that the instructor in the training school has great difficulty in recognizing those students who have had previous instruction in chemistry! Those who have had no previous instruction very frequently grasp the "application" just as readily as those who have had the high school course. More than ever before students are not interested in unusable material. Now more than in former years they demand the reason for the presentation of class material. They are not seeking mere information. They are seeking useful applications.

The content of the more recent texts in chemistry is a great improvement over that presented in former years. It is much more to the point in nursing. However, there is still room for vast improvement. When all that the student nurse is going to have presented on this subject must be presented in from fifteen to forty-five hours (comparatively few schools exceed this) it seems a pity that any examples or applications should be used which do not illustrate something related to the actual care of the patient.

There is a tendency on the part of educational organizations to render more assistance to those schools that need it less than to those with a greater need. We mean by this that lesson plans and course outlines are more easily obtained for courses covering sixty to ninety hours of instruction than for those covering from fifteen to forty-five. There are many reasons for this but the most outstanding reason would appear to be that it is much easier to plan sixty hours of instruction in chemistry than to plan thirty. And it is yet more difficult to plan fifteen.

The problem of the chemistry instructor in the typical school meeting the typical requirements of a typical "state department" or "state board" is staggering. It is overwhelming. Frequently not only does she have a mere fifteen hours allotted to chemistry, but most of the laboratory materials and equipment with which she must work is what may be referred to as makeshift apparatus. Under such teaching conditions, what should the content of the course be? Mine would include the following:

2 hours devoted to oxygen and oxidation, with special reference to therapeutic importance and public health aspects.

2 hours devoted to water and its uses with special reference to its therapeutic value in the treatment of certain diseases.

2 hours devoted to solutions and solution therapy, emphasizing its physiological aspects and importance.

2 hours of ionization, including stain removal.

2 hours devoted to acids and bases, with special references to their therapeutic value in the treatment of disease. Also in reference to the acid-base balance and its importance to health, including a discussion of disease due to its disturbance.

2 hours devoted to salts—with special reference to their therapeutic value.

THIS WAX ISN'T AFRAID OF THE MOP

HOSPITAL superintendents who put Neo-Shine through actual tests are greatly impressed by its stubborn resistance to water. In many cases, 5 or 6 moppings fail to remove the wax.

Here briefly is what makes Neo-Shine waterproof: the highest grade of Carnauba wax . . . bleached, bone-dry shellac . . . and an unusually high wax content—twice that of the ordinary bright-drying wax. No wonder Neo-Shine's protective wax film is tougher. No wonder it isn't afraid of the wet mop.

For your hospital floors you can buy no wax that offers all of Neo-Shine's many advantages. Add together its labor-saving features, its high coverage, its safety on flooring materials, its beauty, and its strong resistance to traffic and water, and you have the real reasons why Neo-Shine today is in greater demand than ever.

Made by the makers of Germa-Medica and Baby-San

The HUNTINGTON LABORATORIES Inc.

DENVER HUNTINGTON, INDIANA TORONTO

Neo-Shine

WATERPROOF · SELF-BUFFING · WAX

FOR YEAR-ROUND SERVICE

—THESE MOST MODERN OF WHEEL CHAIRS

Model No. 703-N

Indoors or out, Gendron Wheel Chairs serve as an ideal medium for health recovery.
Many advances in styling and engineering distinguish our new models—streamlining, seamless steel tubing frame, complete adjustability, Lock-tite and automatic reclining features.

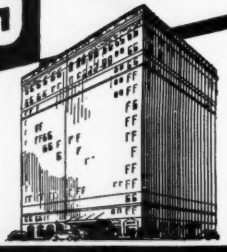
Write for our latest catalog.

Gendron
WHEEL CHAIRS SINCE 1872

THE GENDRON WHEEL CO.
Factory: Toledo, Ohio

Hotel MELBOURNE
CHOICE OF Experienced Travellers FROM EVERYWHERE
Finest Food
BEST LOCATION IN ST. LOUIS

400 ROOMS WITH BATH
$2.50 UP



J. K. BRYAN
Manager

LINDELL AT GRAND

2 hours devoted to common carbon compounds—especially those of value in hospital routine. Also a discussion of the dangers of the misuse of coal tar products. Also the comparative merits of various anesthetics and the dangers attending the use of some.

1 hour of review.

1 hour of examination.

Should the time allotted to the course, and the apparatus and equipment available make possible the employment of thirty hours of instruction, we would still use the above outline with the following extensions and alterations:

2½ hours of energy changes, with special reference to those going on in the normally functioning body.

2½ hours devoted to water and its uses.

2½ hours devoted to oxygen and oxidation.

3 hours devoted to solutions, with additional material on colloids.

2½ hours devoted to acids and bases.

2½ hours devoted to ionization.

3 hours devoted to salts, enlarging on their value in medicine.

4 hours devoted to useful carbon compounds.

4 hours devoted to metabolism, discussing various phases of the normal and abnormal in relation to digestion, blood, tissue, and excretory processes.

Should the course be extended to forty-five hours, the urinalysis tests could be presented, that is, if they are not definitely included in some other division of the curriculum. This leads us to remark that the content of the chemistry course in most schools of nursing must be definitely affected by the content of other courses. For example, the chemistry teacher may use or omit much illustrative material depending on whether or not it has been or is to be presented in the class on operating room technic and anesthesia, dietetics, solutions, or the nursing of medical diseases. Naturally, the student profits by a repetition of a good and useful point in various classes, but when only a minimum curriculum can be presented, the instructors must avoid overlapping and repetition. When a minimum curriculum is presented the anxious instructor must always answer for herself the question: shall I present many topics *en passant* and attempt to cover an entire textbook, just "hitting the high spots," or shall I present a few topics thoroughly? The more limited the class hours, the more imperative it becomes that the instructor base the content of her course upon the amount of working knowledge the student will gain from it.

Other considerations claiming the instructor's attention are: what material is already available in the institution for the teaching of the course? How much will the hospital be willing to spend on the course? Will the course justify the cost, whatever it is? Even a hasty tour through the laboratories of our schools of nursing brings extensive wastefulness to light. And it is difficult to impress students with the sin of wastefulness for in many instances those who are set to teach the students can far surpass them in extravagance. The various laboratories of a hospital all present the possibilities for great waste. The following practices are submitted as time, energy and money savers:

1. The use of neutral litmus instead of red or blue.

2. The saving of the catalytic agent used in the preparation of oxygen. It may be remixed with potassium chlorate and used repeatedly.

3. If the laboratory desk has a single shelf for reagent bottles, put labels on two sides of the bottles so that the labels can be seen without turning several bottles before the right one is located.

4. The use of wax as a coating for labels on the bottles.

5. In most cases, the student may safely be instructed to use exactly one half the amount of the material recommented in the laboratory manual.

6. Have two students use a common ring stand with their individual rings. It saves both equipment and space on the laboratory table.

7. Arrange the students in groups, each group doing a different experiment, thus avoiding a rush after the same reagents.

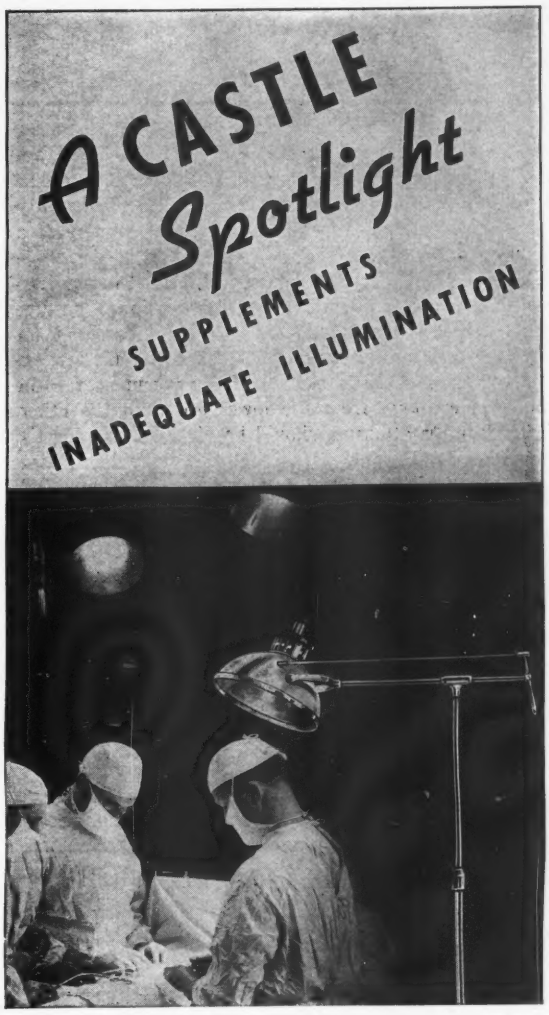
8. Provide containers into which the students will be instructed to pour solutions resulting from one experiment which may be used in another.

9. Instructors will cut down the cost of operation considerably by mixing the solutions themselves instead of allowing each individual student to fix his own. The students remind one of the man who nearly died from taking all his pills at once, because of the fact that one had done him so much good he expected to effect a complete cure with the entire number. Students always seem to think that the way to make an experiment "come out well" is to use a large quantity of reagents.

10. In centrifuging urine for albumin it is not necessary to mix any reagent with the urine.

11. A movable Monel table or ordinary wooden table with acid proof top is very good as a reagent table. Instead of outfitting the laboratory with elaborate individual sets of reagent bottles on the students' desks, two reagent tables may be provided. The dimensions of the tables must be such that the table will fit conveniently into the closet or supply room. The instructor may set up the reagent tables prior to class and one table may serve each row of desks, or materials for experiment number one may be provided on one table, and those for experiment number two may be provided on the second; half of the room may perform the first and second experiment respectively, and then the position of the reagent tables may be changed.

The instruction in chemistry entails much equipment and many materials at best. In many schools the idea seems to be to create an extensive superstructure of "individual equipment" for the students. Each student must have "her own" apparatus and "her own" materials. This is believed to be conducive to learning or acquiring traits of orderliness, cleanliness, carefulness, etc. We believe that considerable reduction could be made in the apparatus and supplies required for instruction in chemistry without depriving the student nurse of the opportunity to learn how to be orderly and clean; these traits can be taught and acquired in the class in nursing procedure and on the wards of the hospital.



SURGEONS never complain of inadequate illumination in the operating room equipped with a Castle Spotlight. Supplementing your present system (until such time as you can get a new Major Castle operating unit), the Castle Spotlight throws a cool, intense, shadow-reducing beam of illumination, giving true tissue values. Although this spotlight yields over 2500 foot candles, there is but 2° F. rise noted on the operating field. The Castle Spotlight is fully adjustable. The ideal supplement to any system of operating illumination.

Write for interesting illustrated booklet
"EFFORTLESS VISION"

WILMOT CASTLE COMPANY
1273 University Ave. Rochester, N. Y.

CASTLE LIGHTS

Personnel Management . . .

(Continued from page 20)

people are working for charity or for the service of humanity; but it is hard for workers of this type to realize any difference between their work in the hospital laundry and that which they would be doing in the employ of a commercial laundry.

Between the two types of labor performed in the hospital there is a very definite line of demarcation. One type calls for highly professional and skilled labor, and for the other type unskilled labor is utilized. With few exceptions, there is little chance of advancement for the ambitious employe from the lower group to the other. However, more attention should be given to training the non-professional employes so that they may learn their work thoroughly and merit and receive promotion. And, when there is an opportunity to give an advancement to an employe already in the organization it goes a long way toward promoting a feeling of good will among the entire group. The hospital executives should realize that many of their employes now look upon the hospital field as their life work.

In many industries, employment is spasmodic or seasonal. That is, the employes are paid by the piece, by the day, or for uncertain periods, whereas in the hospital the work continues each day throughout the year. Even during the depression the hospital retained a larger ratio of its employes than did the outside industries. Therefore, the employes, because of the permanency and sureness of their employment, can afford to work for smaller wages per month; and during the period of a year they will receive more money than they would receive for short time work in the industries at more spectacular salaries. There has been a custom throughout the United States and Canada for hospitals to provide maintenance for their employes (including all types of workers—administrators as well as nurses, laborers and maids) as a part of their salaries. On many occasions this has been necessary because of conditions arising which required the employes to be near the hospital or within reach. Also, hospitals have felt that if they provided maintenance for their employes, their remuneration would be greater than otherwise. However, some employes have felt that they would rather provide their own maintenance and be given the cash equivalent. But experience has shown that where hospitals have granted this the employes have found that the cost of laundry, food, transportation, and other expenses incurred were much greater than they anticipated, and that greater economy was effected by living in the hospital. They have, therefore, asked that maintenance in the hospital be reinstated. The hospital must, of course, give careful consideration to the living conditions and recreation of the employes to whom it furnishes maintenace.

The industrial commissions of the various states have ruled in wage disputes that the value of maintenance for the average employe amounts to $42.50. There is, however, a tendency on the part of employes in discussing wages to ignore this maintenance value. If the hospitals continue the practice of giving maintenance they must establish a more definite policy of placing this monetary value upon the maintenance which is furnished as a part of the employe's compensation. This value should be impressed upon the employe in negotiating his salary.

The department heads in every hospital can aid the hospital administrator in the matter of personnel management. It is impossible for the administrator to know the family life, the hopes and disappointments of every employe in his organization; but the department head who is continually working with the members of his own individual group can reestablish that relationship which in the days of the smaller hospital organizations existed between the employes and the hospital head. The department heads must be sympathetic and listen to the problems and requests of their employes. They can then keep the administrator advised of any changing conditions, increasing demands, and other matters of significance relating to the employees in their departments. It is through the department heads in the larger hospitals that the loyalty and understanding of the hospital's problems and purposes can be established among its employes.

THE HOTEL of THE MONTH
Miami Hotel DAYTON, OHIO
ALBERT
PICK
HOTELS
You'll get more for your money at Pick Hotels. Spacious, comfortable rooms. Delicious food and real personal service. All at moderate prices.
CHICAGO, ILL. ..... GREAT NORTHERN HOTEL
DETROIT, MICHIGAN ..... TULLER HOTEL
DAYTON, OHIO ..... MIAMI HOTEL
COLUMBUS, OHIO ..... CHITTENDEN HOTEL
COLUMBUS, OHIO ..... FORT HAYES HOTEL
TOLEDO, OHIO ..... FORT MEIGS HOTEL
CINCINNATI, OHIO .. FOUNTAIN SQUARE HOTEL
CANTON, OHIO ..... BELDEN HOTEL
SOUTH BEND, INDIANA ..... OLIVER HOTEL
INDIANAPOLIS, INDIANA ..... ANTLERS HOTEL
ANDERSON, INDIANA ..... ANDERSON HOTEL
TERRE HAUTE, INDIANA . TERRE HAUTE HOUSE
ASHLAND, KENTUCKY ..... VENTURA HOTEL
OWENSBORO, KENTUCKY . OWENSBORO HOTEL
JACKSON, TENNESSEE . NEW SOUTHERN HOTEL
ST. LOUIS, MO. ..... MARK TWAIN HOTEL
WACO, TEXAS ..... RALEIGH HOTEL
PICK HOTELS
WHENEVER YOU SEE THE WORD PICK THINK OF ALBERT PICK HOTELS

Addition to Torrance State Hospital

» » Ground-breaking ceremonies for a two-million dollar construction project at Torrance State Hospital, near Blairsville, Pa., were held on November 18.

The project, designed to increase the accommodation at the hospital which houses 1,800 patients, will include construction of two new ward buildings, a new dining room, new power plant and additions to the administration building.

MEDICAL RECORDS DEPARTMENT

EDNA K. HUFFMAN

Director, Training School for Medical Record Librarians, Grant Hospital, Chicago

EDITOR

DIFFERENTIATION BETWEEN MAJOR AND MINOR SURGERY

There is such a constant demand for some means of differentiation between major and minor surgery that the author has attempted to state a definition and to formulate a list of minor operations. These are not to be considered as final but are intended rather to present a basis for discussion. It is suggested that the hospital administration submit both the definition and the list to the medical staff, the medical records librarian and the accounting department; secure suggestions for additions, deductions or changes and transmit them to the author. If there are sufficient of these to warrant formulation of a concensus of opinion, this will be published in about six months.

By T. R. PONTON, M. D.

Editor, HOSPITAL MANAGEMENT

» » » ONE OF THE most constantly recurring questions in the professional aspect of hospital administration is the differentiation between major and minor operations. Records show that there have been many attempts to define either the major or the minor operation or both, and some lists of minor operations have been published. None of these, however, has been satisfactory and it may as well be acknowledged at once that it is impossible to postulate any hard and fast definitions or to make any list which will be applicable to all cases, but perhaps some order may be evolved out of the present chaos.

In making a differentiation between major and minor operations, three points of view must be considered, viz: The danger to the patient, the professional skill required and the cost to the hospital.

DANGER TO THE PATIENT. In considering the danger to the patient, several influences must be studied, the first being the nature of the disease or abnormal condition which indicates the operation. Some of these, in themselves, constitute a definite hazard to life, while others so lower the resistance of the patient as to render even a minor operation a serious matter. An example of the latter is so simple an operation as amputation of a toe in the diabetic.

Second is the influence of disease or other abnormal condition in the patient quite apart from that which indictates the operation, this at times introducing a serious risk to life. A well known example is the danger of hemorrhage in the hemophiliac.

A third consideration is the nature of the operation. Some operations are so difficult to perform as to constitute a serious hazard in themselves, while others require such close contact with important organs or structures as to render any surgical procedure dangerous to life or proper function. An example is the danger of injury to the facial nerve in a mastoid operation.

A fourth important factor is the anesthetic risk. Whenever the operation requires an anesthetic a hazard is introduced, the degree depending on the depth and duration of the anesthesia, the type of anesthetic used, and the personal reaction of the patient.

PROFESSIONAL SKILL. Professional skill in the surgeon is a well recognized safety factor and there is an increasing tendency for surgeons to limit their work to those branches in which each is specially qualified. This is a very important point for consideration since any lack of skill in the particular operation being performed definitely adds to the risk of death or disability.

Consideration of professional skill is not, however, limited to the surgeon. An anesthetic is always a risk, but it is universally recognized that the hazard varies in

The nurse and orderly may also increase or decrease the hazard in proportion to their efficiency. Every eye surgeon is familiar with the danger of nursing which is not of the specialist type during or after a cataract operation.

COST TO THE HOSPITAL. The cost to the hospital is the determining factor from the financial point of view and, in fairness to both the patient and hospital, must be considered. The points affecting this aspect are the duration of the operation, the number of nursing and other personnel required and the amount of supplies used. Here again no hard and fast rules can be set. The writer has known a surgon to take two hours to do a tonsillectomy and while this was still a minor operation from the point of view of risk, it certainly would not be just to any person to make the same charge as would be made to the patient of a surgeon who would do the same operation in less than half an hour.

Definition of Major and Minor Surgery

From the foregoing discussion it would appear that there can be no rigid definition of major and minor surgery. In fact, it is very doubtful if the terms are not misnomers, except from the financial point of view. Looking at the question from the professional aspect, it must be acknowledged that there are few operations which require so slight a degree of skill in their performance as to warrant the use of the minor classification. When the risk to the patient is considered, the use of the term major must be applied to all surgery in which, for any cause whatever, there is a serious risk to life or grave danger of disability, whereas in the minor case, these hazards are slight.

Probably the best differentiation between major and minor surgery is that formulated by Dr. MacEachern in his recent work, "Medical Records in the Hospital." In this the author suggests five points that govern the determination that the operation is to be classed as minor.

1. The abnormal condition which indicated the operation is such that, in itself, it constitutes no serious hazard to the life of the patient.

2. The patient shows no other abnormality which, added to the condition indicating operation, would constitute a serious hazard to life.

3. The operation is not of an extensive or complicated nature and requires only simple equipment, a minimum of assistance and a short period of time.

4. The surgeon is sufficiently trained and experienced in the particular type of operation to be performed to obviate the addition of any hazard to the life of the patient.

5. If an anesthetic is necessary or advisable, it should not be of a deep and lasting nature, should be selected with care and should be administered by an anesthetist who is skilled in administration of the particular types of anesthesia.

While it is felt that no list of major and minor operations can be formulated which would be applicable under all circumstances, yet it is conceded that hospitals are demanding guidance. The following list of operations which are usually considered to be minor, is therefore appended with a definite reservation that any of them may, under special circumstances, involve a serious hazard to the patient, require a higher than usual degree of professional skill or involve considerable cost, and for any one or more of these reasons will be transferred to the major class.

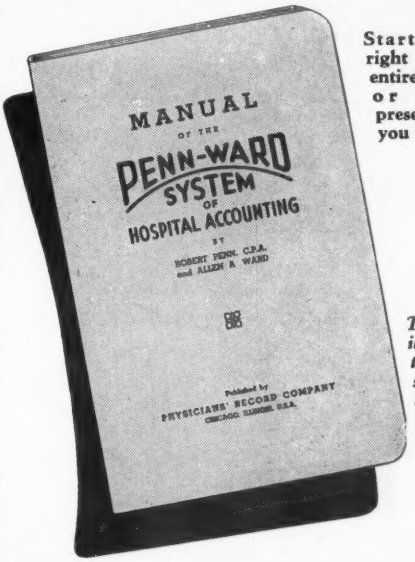
List of Minor Operations

(* If the organ or part is superficial or easily accessible.)

Adenectomy*
Adenoidectomy
Adenotomy
Administration Diarsenol (all arsenicals)
Administration Serum
Advancement Capsular
Advancement Eye Muscle
Alveolectomy
Amputation—simple, such as finger, toe
Antrotomy
Apicectomy
Aponeurotomy*
Application Plaster
Arteriotomy*
Arytenoidectomy
Aspiration*
Avulsion
Blepharoplasty—refer to specific operation
Blepharorrhaphy
Blepharosphincterectomy
Blepharotomy
Bronchoscopy
Canthectomy
Canthoplasty
Canthorrhaphy
Canthotomy
Capsulectomy
Capsulorrhaphy
Capsulotomy
Catheterization
Cauterization*
Chilorrhaphy
Chilotomy
Ciliarotomy
Ciliectomy
Circumcision
Cirsectomy*
Clitoridectomy
Clitoridotomy
Closure Canaliculus
Coloclysis
Colpotomy
Corelysis
Coreoplasty
Curettage*
Cyclotomy
Cystectasia
Cystoscopy
Cystosigmoidostomy
Cystotomy
Dacryocystectomy
Dacryocystotomy
Desmotomy*
Diclidotomy*
Dilaceration Cataract
Dilatation*
Discission Cataract
Drainage Abscess*
Drainage Bursitis*
Drainage Carbuncle
Drainage Cellulitis*
Drainage Chalazion
Drainage Furuncle
Drainage Hematoma*
Drainage Tenosynovitis
Dressing, (burn, wound etc.)
Electrocoagulation*
Electrolysis
Enteroclysis
Epididymectomy
Epididymotomy
Epididymovasotomy
Epilation
Episiorrhaphy
Episiotomy
Esophagoscopy
Esophagotomy
Examination (light or no anesthesia)
Excision Cyst*
Excision Fissure in Ano
Excision Pterygium
Excision Scar Tissue*
Excision Specimen for Examination*
Excision Ulcer*
Exploration* (not to include lapartomy)
Expression*
Extraction Cataract
Extraction, Magnet
Extraction Teeth
Extubation
Fasciotomy*
Gingivectomy
Grattage
Hemorrhoidectomy
Hyalonyxis
Hydrodictiotomy
Hymenectomy
Hymenorrhaphy
Hymenotomy
Hyperextension
Hyposcheotomy
Incision*
Incudectomy
Induction Abortion
Induction Labor
Infiltration*
Injection* (air, etc.)
Injection Hydrocele
Injection Intravenous
Injection Nerve*
Insertion Catheter
Insertion Pessary
Insertion Radium
Insufflation (intratracheal, lung)
Intubation
Iridectomy
Iridesis
Iridocystectomy
Iridodialysis
Iridosclerotomy
Iridotasis

Iridotomy
Irrigation*
Keratectomy
Keratocentesis
Keratonyxis
Keratoplasty
Keratotomy
Lacrimotomy
Laryngocentesis
Laryngoscopy
Laryngostomy
Laryngotomy
Ligation*
Lipectomy*
Lithotomy
Lithotrity
Manipulation
Massage*
Mastotomy
Meatotomy
Myotasis
Myotomy
Myringectomy
Myringoplasty
Myringotomy
Needling Lens
Needling Nevus*
Neurotomy*
Nymphectomy
Odontoschisis
Odontotripsy
Ophthalmotomy
Orchidotomy
Ototomy
Packing Nose
Packing Uterus
Packing Vagina
Packing Wound
Paracentesis*
Patellapexy
Perineorrhaphy
Perineotomy
Peritomy
Phacectomy
Pharyngotomy
Phlebectomy*
Phlebostasis
Phlebotomy*
Plastic*
Pleuroclysis
Plicotomy
Probing Lacrimal Duct
Proctectasia
Proctoclysis
Proctoscopy
Proctosigmoidoscopy
Pubiotomy
Puncture*
Reduction Dislocation, Closed
Reduction Fracture, Closed
Removal, Foreign Body*
Removal, Nasal Spur
Removal, Placenta
Removal, Polypus
Removal, Pterygium
Repair, Sphincter Ani
Rhacicentesis
Rhinorrhaphy
Sclerectomy
Scleriritomy
Scleronyxis
Sclerostomy
Sclerotomy
Scrotectomy
Scrotopexy
Septectomy
Septotomy
Sigmoidoscopy
Sphincterectomy
Sphincterolysis
Sphincteroplasty*
Sphincterotomy*
Splinting
Stapedectomy
Stapediotenotomy
Staphylectomy
Staphylorrhaphy
Staphylotomy
Strapping
Suture Wound*
Symphysiotomy
Synechotomy*
Syringotomy
Tarsorrhaphy
Tattooing Cornea
Tenectomy*
Tenodesis
Tenorrhaphy*
Tenotomy
Thoracocentesis
Thoracotomy
Thrombectomy*
Tonsillectomy
Tonsillotomy
Tracheloplasty
Tracheotomy
Transfusion, Blood
Transplation Pterygium
Trephining Cornea
Turbinectomy
Turbinotomy
Ulectomy*
Uletomy*
Urethrorrhaphy
Urethrotomy, External
Urethrotomy, Internal
Varicocelectomy
Vasectomy
Vasopuncture
Vasorrhaphy
Vasostomy
Vasotomy
Venipuncture*
Ventriculocordectomy
Ventriculography
Vesiculectomy
Vesiculotomy
Vestibulotomy
Wiring Teeth

NOW is the time to "MODERNIZE" your Accounting System for 1938



Start the new year right . . . adopt an entirely new system or revise your present one to give you BETTER results.

This simple, flexible, authoritative system will solve your problems.

PENN-WARD SYSTEM OF HOSPITAL ACCOUNTING

YEARS of hospital auditing, research and accounting on the part of the authors culminated in this systemized, easy-to-follow plan—approved by the A.H.A. and the one described in the outstanding reference book, "Hospital Organization and Management".

The Penn-Ward system is extremely FLEXIBLE . . . adapted to the requirements of large or small hospitals. The new Instruction Manual gives directions that are definite, simple and complete.

LOW PRICED . . . far lower than other specially printed accounting forms, and there is NO INSTALLATION COST.

WRITE FOR DETAILS. Check the Penn-Ward System against whatever system you are now using and you will see the advantages of adopting Penn-Ward forms. We'll gladly send you Folder No. 26 of Sample Forms, New Manual of Instruction and Price List 1524 C. Write today!

Voucher Register and Income Account as recorded on the simplified Penn-Ward Daily Summary of Transactions is based on the Chart of Accounting recommended by The A.H.A. Accounting Committee in 1937 report.

Physicians' Record Co.

[The Largest Publishers of Hospital and Medical Records]

161 W. Harrison St. Chicago, Ill.

B12-37

We Have a STANDARDIZED FORM for Every Hospital Purpose

ANESTHESIA, PATHOLOGY, X-RAY

BEN MORGAN, M.D.
Anesthetist, Grant Hospital
Chicago

JAMES T. CASE, M.D.
Professor of Roentgenology, Northwestern University, Chicago

JOSIAH J. MOORE, M.D.
Director, Moore Clinical Laboratories, Chicago

CONTRIBUTING EDITORS

CYCLOPROPANE

By BEN MORGAN, M. D.
Chief Anesthetist, Grant Hospital, Chicago, Ill.

» » » THE HISTORY, chemistry and accepted physiological action of cyclopropane, together with a guide for its administration is to be found in leaflets accompanying every tank purchased. The manufacturing formula was worked out by Purdue University and turned over to one of the chemical companies for production and distribution.

From the beginning, cyclopropane was branded as a very potent anesthetic gas full of dangers, especially when used by beginners, but having many valuable features when properly administered. Among the many forebodings listed were such warnings as laryngeal spasm, respiratory arrest and danger of too deep anesthesia. With these cautions uppermost in mind, the well-trained minority cautiously went ahead, making observations and deductions of eminent value and continuously piling up the type of history that determines the suitability of any product for continued use. As an added safeguard the distributors required the signature of a physician before filling cyclopropane orders. While they received some criticism, this was greatly appreciated in the ranks of advanced anesthetists.

Most of the literature on cyclopropane is a duplication of the original report of Doctor Waters of Madison, Wisconsin. In fact, I have noted no particular points of importance that have been brought out during the year. Our own experience follows along the conventional paths. There are about three main variations in the technic of administration, all leading to the same results:

First Method: Fill bag to one-half of its capacity with oxygen. Flow cyclopropane and oxygen at the ratio of about one to two until the patient is anesthetized. Then turn off both gases. Repeat the flow of cyclopropane and oxygen if needed or if metabolism of oxygen or leakage causes bag to deflate.

Second Method: Fill the bag with oxygen, maintaining a constant flow of oxygen at the supposed metabolic rate. (It would be nice to have a metabolism test taken on all patients) Turn in cyclopropane at 200 cc. per minute for one minute, step it up to 300 cc., 400 cc., and 500 cc. each succeeding minute until anesthesia is established.

Third Method: Substitute air for oxygen and start with two quarts of air, add one-half pint of cyclopropane, wait until patient breathes regularly for six breaths, then add one pint of cyclopropane and again wait for six breaths of smooth breathing. Now add the metabolic rate of oxygen. Next add one quart of cyclopropane and begin to get ready to operate. The total time is about two to three minutes. The bag will be distended to a little less than three quarts because it requires about one quart of cyclopropane in the blood stream and tissues for anesthesia in a 120 to 160 pound person under normal operative conditions. The last method differs only in the use of air instead of oxygen. This was discovered about two and one-half years ago when we began to use cyclopropane and found that pure oxygen produced a startling bright red color characteristic of over oxygenation. Following our anesthetic pattern we teach to add oxygen to correct blueness and conversely remove excess oxygen from the flush to achieve a normal color. We have further found that with this method the embarrassment to respiration in relation to the degree of relaxation is considerably less. The incidence of post-anesthetic headache has been considerably reduced by the elimination of over-oxygenation.

The wise anesthetist usually follows along proven lines. It is advisable to take any of the above suggestions and proceed. The first one is to be avoided because it hardly seems scientific to allow the oxygen to be consumed out of the mixture without replacing it. There is a potential danger that the remaining contents of the bag will contain a supercharged amount of cyclopropane, A little flow of oxygen is always good in any form of anesthesia, even spinal or an extensive local.

How to Learn to Administer Cyclopropane

After following the prescribed suggestions as closely as possible variations can be worked out to meet almost every requirement. If, however, there is lack of sympathetic carefulness on the part of the surgeon, it is better not to use cyclopropane except for superficial surgery, i. e., outside the abdomen.

Rule No. 1—Read all of the literature until you can see its application to the anesthetic pattern in your dreams. Don't wait for the operation to start to gather your data.

Rule No. 2—Become versed in resuscitation. This is important because failing respiration is the chief obstacle to successful anesthesia with cyclopropane. The anesthetist should be well practiced in this at all times anyway. Practice on perfectly normal cases in squeezing the bag —not too much but in rhythm and synchronous with inspiration, releasing the bag with a snap at the end of the inspiration. This tends to remove fear of breathing failures by familiarizing one with the music, mechanics and physiology of respiration. This is one of the first requirements we make of our anesthetists. They must also know how best to establish adequate airway by position and mechanical aid such as insertion of airways, nasal tubes and if possible, "direct vision" insertion of tracheal catheters.

The reason for the above requirement is based on the important fact that we have been unable to produce an over-dose of cyclopropane in a single person or laboratory animal in which pure oxygen and slow (16 per minute) rhythmic compression of the gas bag has not corrected within a short time. Carbon dioxid is not a respiratory stimulant for over-dose of cyclopropane.

We do not mean to insinuate that every case we give stops breathing. Far from it. Neither do we expect every operative patient to need stimulants although every well prepared operating room has all ordinary stimulants easily available. In the majority of cases where there is need for respiratory aid, it is a mere matter of increasing oxygen, and squeezing the rebreathing bag a few times to reestablish respiratory exchange. As this simple remedy overcomes the principle objection to cyclopropane, we do not consider this a barrier of any particular consequence.

Why all the writers insist on a special profound knowledge before using cyclopropane is beyond me. The profound knowledge about cyclopropane is that same profound knowledge that applies to any anesthetic agent. Each anesthetic has its picture and each patient is primarily a medical case but offers no more problems with cyclopropane than with (safe) ether or any other anesthetic. If unusual conditions arise, such as collapsed vocal chords, with cyclopropane or any other anesthetic agent, a laryngoscopy and insertion of a tracheal catheter is required or they will be signed out as "heart failure" in which the post shows nothing. Even a further step may be necessary in edema of the glottis such as occurred in one of my own cases caused by a gunshot wound. This required a tracheotomy which I did before removing the tracheal tube.

Looking further for troubles in cyclopropane, one paper refers to "a number of sudden unexplainable deaths in the course of this anesthetic, and it should be given only by one thoroughly familiar with the technic. There is no particular indication for the use of cyclopropane in pelvic surgery". We do not know from what data Doctor Charles Lintgen made these deductions. There is an average of one death per week in the Chicago area from anesthetic causes or a combination of surgical shock and anesthesia with no relation to cyclopropane in which the surgery shares equal blame with the anesthetist. Several (about seven) of these deaths have been from disturbance of the cortical motor area and heat center producing extreme uncontrolled spasm and high temperature. Pelvic surgery with us enjoys the height of gratification since using cyclopropane. This ultra-satisfaction is based on quality of relaxation for the surgery and better recoveries.

Further guidance in cyclopropane usage is credited to studies of the actual concentration of cyclopropane in air and blood by Doctor Benjamin H. Robbins, showing that corneal reflexes are lost with 18 per cent, abdominal relaxation occurs with 22.3 per cent, wink reflexes are lost with 27.3 per cent, costal paralysis occurs with 33.6 per cent, respiratory arrest comes on 35.8 per cent. The actual amount of cyclopropane absorbed into the blood in milligrams per 100 cc. of blood is about two-thirds of the per cent contained in the inspiration—e.g., 18 per cent of cyclopropane in the air gave 13.9 milligrams per 100 cc. in the blood while 35.8 per cent in inspiration gave 28.2 milligrams per 100 cc. blood. The last figure produced respiratory arrest. Therefore, it may be seen that the range between abdominal relaxation and costal paralysis is the difference of 22.3 and 33.6, or about 50 per cent. In an actual anesthetic the cyclopropane would have to be increased all of 50 per cent in the bag to approach the danger point. It would seem that with ordinary care these higher concentrations would not be approached blindly. One would hardly expect to see an ether anesthetic or any other anesthetic such as spinal or Avertin, increased 50 per cent without serious consequences. We thank Doctor Robbins for his exhaustive studies on laboratory animals. We have good reason to accept these as applying to patients because in all other inhalation anesthetic gases, the corresponding results are about identical.

I like the description of the administration of cyclopropane in a splendid article by Doctor P. F. Bonham of Houston, Texas, "The carbon dioxid absorption technic is the most accurate and most generally used method in the administration of cyclopropane. The writer begins his administration by filling the bag about two-thirds full of oxygen or enough to allow for the tidal excursion of patient's respiration and then adding cyclopropane and more oxygen, each at the rate of 500 cc. per minute for three to five minutes, then cuts off the cyclopropane for a few minutes to allow it to fully circulate or become absorbed; then more may be added from time to time as needed throughout the operation but always with the addition of extra oxygen. Oxygen, of course, is continued at metabolic rate, or about 300 to 500 cc. per minute, all through the operation". This is essentially the same as Doctor Thomas of Pittsburgh and Doctor Waters of Madison but differs from Sister Borromea of Peoria.

In all the corroborative work that has been carried out independently in various locations, we find it proved beyond any doubt whatsoever that cyclopropane does not upset liver functions after prolonged and repeated administrations, does not change the metabolism or coagu-

lation time, nor is there any functional change in any organ or tissue. What more can be said for a general anesthetic where and if ether is not to be used.

It goes without saying that the anesthetist should be trained in anesthesia. But this applies to any anesthesia. Let not the mind become sluggish to the fact that ether is still the standard to which all anesthetics check and far too many study gas anesthesia only to slight ether technic. When things go wrong all of us reach for the ether handle. It is true that liver function is always impaired in ether anesthesia but it is also true that the average liver is impaired after a glass of Bourbon. Just as gas may be given for many operations without apparent bad after-effects, so too does thin ether still enjoy a great margin of safety. Ether anesthesia is here referred to only to keep before the anesthetist the standard pattern or picture of the accepted basic anesthetic and prevent flying off at a tangent in a belief that a nice cyclopropane result is setting a new pace in the field.

One rule to follow in selecting cyclopropane as the anesthetic of choice for a given patient is to study the history and laboratory report and then ask yourself one question, "Would an average ingestion of alcohol tend to impair the functions of liver, kidney, metabolism or the respiratory tract?" If they could not stand this, ether is contraindicated and cyclopropane would be indicated.

In the February issue of HOSPITAL MANAGEMENT of this year, we published a resume of the anesthesia signs and symptoms pointing out a pattern by which a per cent evaluation of signs is used as a guide for the anesthetist. Also included were the salient points of each type of anesthesia: Nitrous oxid characterized by blueness, good pulse, good respiration and active reflexes; ethylene characterized by better color but still some blueness, fair pulse, soft respirations and better reflex control, ether—perfect color and pulse, better respiration than normal, and reflexes under perfect control; cyclopropane—perfect color, pulse splendid, respiration soft to absent with reflex control well within the management of the experienced anesthetist. When we refer to pulse, we do not mean the taking of pulse by the out-of-date finger method but rather by the stethescope and armband sphygmomanometer. By judging respiration we do not mean the mere rate of breathing by count—we mean that the anesthetist should get into the rhythm of the patient's respiration, breath like the patient, both in rate and volume as expressed by the rate and volume exchange of the bag and determine by subjective impression if the respiration is within reasonable limits.

The necessary units of equipment for cyclopropane administration are the (1) circuit breathing unit, consisting of mask, double breathing tube, carbon dioxid remover, double valve and gas bag, (2) the oxygen dry flow meter with cubic centimeter dry flow calibration, (3) cyclopropane unit with cubic centimeter calibration. The objection to the water flow meter is that the viscosity makes the fine flow of gases through a water medium impossible.

In conclusion let us say that we can see no real objections to cyclopropane anesthesia. Although it is a potent anesthetic drug, it has a wide enough range of safety for control, it allows adequate relaxation with ample oxygen, it has no toxic effects on liver, kidney, or metabolic function, and the recovery is always as good and usually better than the other inhalation anesthetics.

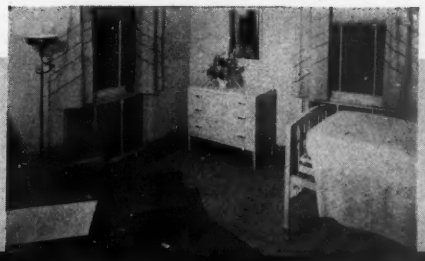
Workmen's Compensation Act . . .

(Continued from page 21)

trade, business or occupation "for pecuniary gain". In denying the claim, and holding that the hospital was not an "occupation" under the act, the New York court stated that " 'pecuniary gain' as used in the statute means that the employer must be carrying on a trade, business or occupation for gain. The certificate of incorporation of the employer (hospital) shows that it is an eleemonsynary institution, organized to care for sick and injured persons, and the evidence fails to show that it was carrying on a business for pecuniary gain. The certificate of incorporation shows that the purpose of the hospital is not profit, but charity, and although revenues are received from some who are able to pay, this fact does not change the defendant's standing as a charitable institution; all of the receipts are devoted to the charitable purposes of the institution". The ruling in this case is that in New York a non-profit hospital, regardless of how large in size, or in the amount of equipment, machinery appliances, or location, is not an "occupation" under the act. However, the inference of this ruling is that a large hospital conducted for profit, of possibly more than three stories, and containing considerable equipment, appliances and machinery, would have been held to be an "occupation" under the New York Workmen's Compensation Act.[4]

In recapitulation, it may be stated as a general rule that the small one, two and possibly three story hospital, whether conducted as a charity or for profit, or whether located in an urban or rural community, is not an "occupation" under a state workmen's compensation act. In those states whose judiciary have a very liberal and beneficent attitude towards hospitals and their future progress, a hospital whether conducted for profit or as a charity, and regardless of its size, machinery, equipment, and location, would be held not to be an "occupation" under the compensation act. However, where a state has an express provision in its workmen's compensation act which makes it apply only to "occupations" conducted for gain, then a non-profit hospital, regardless of its size, equipment and location, would be held not to be an "occupation"; although large hospitals conducted for profit, similar or larger in size than the Hahnemann Hospital, would be held to be an "occupation". In some states, the workmen's compensation act does not appear to apply to either profit or non-profit hospitals, but only does so indirectly as a result of safety ordinances of the city which subject the hospital to its regulations. In such states, the hospital would be held an "occupation", regardless as to whether it is conducted as a charity or for profit, providing it is of large size (possibly more than three stories in height), and containing considerable equipment, machinery and appliances. However, if the hospital, in a state with such an act, should be located in the country or in a small town, then regardless of its size, machinery and equipment, and whether conducted for profit or as a charity, it would be held not to be an "occupation".

[4] A claim for workmen's compensation was upheld by the New York Court of Appeals against a charitable hospital (really against its insurance carrier) which had voluntarily elected to come under the act and had provided itself with workmen's compensation insurance. Bernstein v. Beth Israel Hospital 236 N. Y. 268, 140 N.E. 684 (1923).



THE HOSPITAL HOUSEKEEPER

MRS. GRACE H. BRIGHAM
Biltmore Hotel
Providence, R. I.

MRS. ALTA LA BELLE
Michael Reese Hospital
Chicago

MRS. DORIS L. DUNGAN
West Jersey Homeopathic Hospital,
Camden, N. J.

MRS ALICE M. ELDRIDGE
Fairmont Hospital
San Leandro, Calif.

CONTRIBUTING EDITORS

THE GOVERNMENT'S INTEREST IN OUR SLEEP

By NORMAN E. MATTISON, M. D.
New York, N. Y.

» » » IN WHATEVER WAY one comprehends and interprets the rapidly-moving political scene, there is one fundamental on which every well-informed person agrees—that our government takes a paternal interest in every citizen from one extreme of his life's span to the other. Casual observers and students of economics alike think of this fostering interest of the government as relating principally to such factors as health, food, clothing, housing, employment, et al, but one important fundamental is entirely overlooked by many.

This relates to the interest and attention of one of our most important governmental agencies in the matter of our sleep. And so, without losing any of the sense of values and proportions in the other factors relating to the welfare and well-being of our citizenry, sleep becomes an important figure in the government's constructive pattern of our national life.

The beginning of the first far-reaching governmental interest and activity in the matter of sleep has been within very recent years. And as some one authorized agency is required to supervise and direct changes in any industrial art, the National Bureau of Standards was designated to conduct the work. The first approach was made responsive to an indicated need for standardizing mattresses for hospitals and institutions, which initiated at least a beginning toward better individual sleeping conditions, and resultingly better sleep for the many.

It is a matter of record [1] that in 1933, "at the instance of the American Hospital Association, a general conference of representative manufacturers, distributors, and users of mattresses for hospitals appointed a special committee to adopt a recommended commercial standard for this commodity.

This conference committee continued its meetings with the Division of Trade Standards of the National Bureau of Standards, in Washington, and less than two years later there was promulgated a new commercial standard for this important integer in our recumbent sleep and rest, the thought being doubtless that whatever conduced to best rest and slumber for hospitalized persons, would, by the same token, apply to persons in their own homes.

The standards for mattresses for hospitals, may, with advantage, carry forward to an enlarged sphere of usefulness, as these standards relate to the enormously larger field of mattresses in the home. Indeed, whatever conduces to the comfort of a hospitalized person will also serve usefully in the usual home conditions. And as the total number of hospital beds in this country (1,100,000, not including bassinets) is a small proportion of all beds in nightly use, the lessons learned from the government's deliberations may conceivably serve for the benefit of the large majority of persons in their usual surroundings at home.

As this present study relates solely to a consideration of governmental standards of mattresses for hospitals, for the sake of some degree of completeness the second section of the Standards Bureau report is considered first. This section relates to curled-hair mattresses and the way the government's authorized agency interprets the requirements of their use, especially as referring to the filling. Whether the filler in any particular case be Grade A, B, or C hair, or the material used in any other mattress of the solid type, it is required that it shall be evenly distributed—the primary filling. For the middle one-third area of both the top and bottom of the mattress, the same grade of hair—about 15 percent of the total amount—shall also be evenly distributed. This is the crown filling.

The familiar practice of "crowning" of the hair type of solid mattress construction, therefore, is a recognition that the center third of the mattress is affected by the recumbent sleeper in a way substantially different from

[1] Commercial Standards CS 54—35, Mattresses for Hospitals, National Bureau of Standards, Washington, 1936.

the way the upper or the lower third of the mattress affected by the same sleeper. Thus, hair mattresses have been turned over endwise or sidewise countless times for generations, and why?—simply in order to lessen the degree of the inevitable "sag" in the middle. Sooner or later, however, we have a hollow or sag in the middle third of the mattress, which develops because the initia "crowning," the frequent turning-over, and the occasional rebuilding of the mattress, do not remedy a fundamental defect of construction. And this applies not only to the solid types of mattress construction but also to the resilient innerspring composition.

Reverting now to the Standards Bureau report relating to innerspring mattresses, the attention of the conjoined Standing Committee and the Division of Trade Standards has already been directed to one important phase of the commercial standards for mattresses for hospitals. This relates to the resiliency of spring units as integers of innerspring mattresses; and it is a gratifying indication of progress and improvement in the art that earnest consideration has been given to the changes proposed.

The requirements of the standards of spring units, as above, as to resiliency [2], subscribe to the same principles common to substantially all innerspring mattresses, the "compression factor" alone of the helical springs being the only changes as to present existing standards. There is, however, another factor which has been directed within recent months to the attention of the Division of Trade Standards and the Standing Committee meeting with it.

This relates to a new principle of spring resistances, which principle comprehends that the sleeper's recumbent body does not weigh the same in all of its parts—that one's head or feet weigh substantially less than the hip section of the body, for example—and that therefore the degree of spring compression should be proportional to these regional differences in body weight.

The resulting "differential spring" principle has been advanced, therefore, and a recent communication to the writer from the Division of Trade Standards states that the Committee is very sympathetic to the matter which will be considered further at the next meeting—this with a view to a change in the standards of the prevalent present types of uniform spring resistances.

This engenders the thought that the resiliency of mattress spring units for hospitals can never be completely disassociated from the resiliency of mattress spring units in the home. Every hospital mattress, whatever its resiliency, has an antecedent as to use, in a home mattress of some degree of spring resistance—or lack of it.

And this further thought indicates that the physical and nervous welfare of every hospital patient would be enhanced by the use of a mattress similar, as to its physical properties, to the usual one at home. And, of greatest advantage, that both mattresses should also afford the maximum of mechanically correct spring pressures, proportional to known differences in the body weight in its different areas. These proportional weight differences, be it observed, are fairly constant in all normal subjects whatever the height, weight, age or sex.

The changes in environmental demands from home to hospital would thus be one of comparatively easy transition, not profound adjustments made necessary at times by these changes. The incoming hospital patient would thus not have the added tax of adaptation to change in the important particular of his bed; and the nearer alike the two mattress constructions, whether of innersprings or hair, the better the patient's physical and nervous comfort and resulting progress.

So long as an authorized governmental agency, coordinating with a representative committee in this field, is interested in improvements in the art of mattress making, the leaven of change will inevitably work toward better sleep.

And that, whatever the means, interests everyone, in or out of hospitals, at home or away, from one extreme of his life's span to the other!

[2] Ibid, p. 4.

Cleaning Terrazzo Floors

» » A hospital executive writes asking how to remove wine stains from terrazzo floors. Repeal of prohibition apparently has some disadvantages. Anyway, several of the terrazzo floor firms were called and the best advice they could give was that if the stain had not penetrated too deeply, sanding would remove it, but for deep penetration they all thought it would be better to leave it alone. The manufacturer who suggested sanding advised waxing to prevent penetration. For general cleaning, Doctor William Walsh, hospital consultant, kindly furnished some good advice:

Strong alkali, caustic, potash, strong soda and soaps should not be used for cleaning terrazzo floors, except as indicated below.

A recent survey showed that some twenty-six cleaning materials were being used, including these substances, and various users expressed themselves satisfied with the results, but in view of the warnings against the damage that may be caused by expansion of alkali crystals or formation of gummy substances that are issued by reputable sources, it would seem advisable to avoid the use of such cleaners as consist of or contain disapproved substances. The recommendations which were made on the basis of this survey were dry cleaning with brushes and occasional scrubbings with a neutral soap as necessary.*

The recommended cleaning procedure is as follows:

a. Sweep with a floor brush daily.

b. Scrub only when the floor is so dirty that sweeping will not clean.

c. A scrubbing machine or mops may be employed.

The floor may need scrubbing only once a month, but will require it oftener if there is heavy usage, perhaps even several times a day in places if dirt is being tracked in during bad weather.

The following are cleansing solutions that have been recommended for scrubbing or mopping terrazzo floors when water alone will not cleanse.

½ oz. of trisodium phosphate or sodium metasilicate per gallon of hot water.

1 to 2 oz. of modified soda cleaner to 10 quarts of hot water.

One part anhydrous neutral soap (powdered soap or soap chips) to three parts of hot water to form a diluted soap solution. Add one to two teacups of this to a bucket of hot water, the amount depending upon

the condition of the floor. Soft water only should be used, to reduce the likelihood of gummy films forming and to facilitate cleaning.

Rinsing is very important. If a soda cleanser is not rinsed off completely, expanding soda crystals in crevices or in the porous cement will have a tendency to dislodge the surface chips, causing pitting. If soap is not rinsed off, it will build up a gummy film which collects dirt. The use of any strong cleanser must be avoided because of the fact that it may destroy the cement or binder. Waxing will afford a certain amount of protection against cleaning compounds and reduce the need for scrubbing. However, waxing will not necessarily reduce the cost of upkeep or simplify maintenance. Of course, considerable labor is required for the application of even a water-emulsion or no-rubbing wax. In caring for a waxed floor the use of hot water for scrubbing, which is generally recommended for terrazzo, must be restricted because of the tendency of heat to remove wax.

*"A Study of Floors," by Paul E. Holcombe, from *Skyscraper Management.*

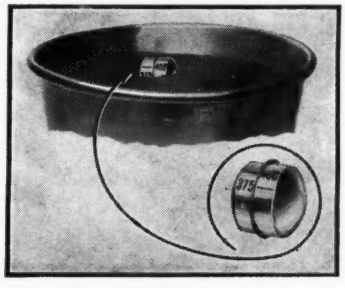
NEW EQUIPMENT

Color Photography

» » Photography is playing an increasingly important part in the hospital both as a medium for recording pathological conditions and also for teaching purposes. In most instances the black and white photograph serves the purpose, but in some, reproduction of natural colors is essential and in these, color photography has proved satisfactory.

Some processes require skill and talent for securing satisfactory results, but the sponsors of the Finlay process are now claiming that, "Today anyone who has the desire to use color in his work is able to do so, and it is not essential that he have years of photographic training behind him. The process, known as the Finlay Process of Natural Color Photography, has so simplified the art of recording in color that the pathologist and all those in the medical profession can now by the means of the Finlay Process register interesting findings in color just as easily as they do in black and white."

Non-Breakable Floating Thermometer



» » The Thermosphere, illustrated above, is a new, all-metal, non-breakable floating thermometer for measuring the temperature of hot liquids, manufactured by the Raytheon Mfg. Co. It is constructed in the form of a small metal ball with a temperature scale engraved on

A Year-Around NECESSITY
EZY-RUG
Colored Rubber Link
MATTING
Prevents tracking in germ laden dirt and grit by trapping it at the door. Ends sloppy, slippery floors.. Reduces cleaning costs. Modernizes and beautifies lobbies and corridors. Slip-proof and trip-proof. Hospital name can be incorporated in mat. Write for folder and price on mats for all purposes. A staff of matting engineers and distributors throughout the country. Illustrated is the Mercy Hospital, Pittsburgh, Installation.
AMERICAN MAT CORPORATION
1715 Adams Street
TOLEDO, OHIO

THIS SILENT FLOOR MACHINE

So QUIET in operation that its name "SPHINX" is synonymous with the hushed orderliness of hospital routine. It scrubs, waxes and polishes with equal efficiency. "Smoothly Silent" say nurses; "Sanitary and Quiet" say doctors; "Cuts Costs" say Superintendents. Reduces floor maintenance costs to an amazing degree and actually pays for itself out of savings in time, labor and materials. So simple that any inexperienced attendant can operate it successfully. In leading hospitals from coast to coast the silent whisper of the "SPHINX" tells of efficient speedy floor maintenance.

A FREE TRIAL OFFER PROVED

. . . to hundreds of superintendents that the Lincoln Single-Disc surpassed every requirement for speed and efficiency — that its silent operation and life-long service was a revelation when compared to other machines. See it glide across your floors leaving a clean sanitary surface—be convinced by a FREE test. Investigate it TODAY.

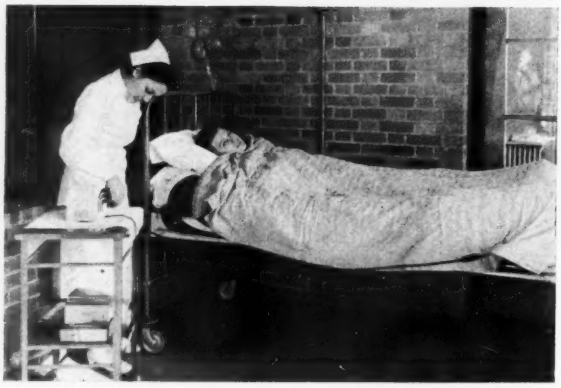
MAIL COUPON TODAY

LINCOLN SCHLUETER FLOOR MACHINERY CO. 1237
204 W. Grand Ave., Chicago, Ill.
Please send me full details of your 5-day FREE TRIAL OFFER; also complete specifications on the New Lincoln Single-Disc Machine.
Name.....
Address.....
City..... State.....

the outside. Inside is a bimetallic mechanism, which, being affected by the heat of the liquid, makes the Thermosphere revolve and causes successive numbers on the scale to appear above the surface. When the Thermosphere stops revolving, the uppermost number indicates the temperature in degrees fahrenheit.

The standard Thermosphere is 1½ inches in diameter, chromium plated. The scale extends from 350 to 400 F. and is tested for accuracy over that range. Size can be chromium plated. The scale extends from 350 to 400° F. 600° F.

Electric Comforter



» » Four years ago scientists in the General Electric research laboratory at Schenectady embarked on a thorough study of bedroom sleeping conditions, to which so great a portion of an average life is subject. Air conditioning in every phase was examined, including sleeping hoods which furnish purified, vitalized air direct to the sleeper. Among the by-products which emerged from this study was an electric comforter, designed to afford safe, automatically controlled warmth to a sleeping individual without the necessity of heaped-up blankets or insufficient fresh air. The comforter was made up in sample lots and distributed in certain areas last year, following which a user survey was made. On the basis of results the comforter has now been redesigned for general use.

Although it weighs no more than an average blanket, the electric comforter automatically maintains a desired temperature despite changes in weather during the night. It is composed of two thicknesses of light weight material between which many feet of specially insulated waterproof flexible wire have been sewn in a zigzag pattern. The wires are connected to a control box placed at the head of the bed.

Scientifically Postured Chair

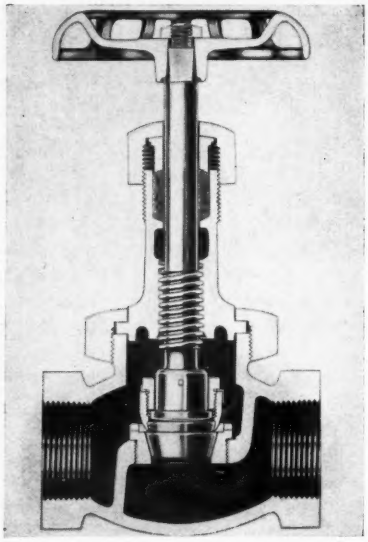
» » "Parlor Comfort" is now a reality with a new folding chair which is "scientifically postured" to relax the entire body.

Lyon Metal Products, Incorporated, Aurora, Illinois, manufacturer of folding chairs, has just redesigned their entire line. New features include extra wide seat (15-5/16 inches wide by 14½ inches deep) curved to fit the body and located with relation to the form fitting back rest to support either a small or large person in an exceptionally restful manner.

Channel steel frame supports the cross braced cantilever type seat. The chair has only three moving parts which accounts for the quiet operation when being opened or closed. Live rubber feet on all four legs are standard and eliminate the usual clatter and bang when being moved about. Special tear and pinch proof hinges and folding and stacking are additional features.

Simplified design and production methods permit any combination of seat and back as well as any color combination in upholstery or finish which may be desired.

New Plug-Type Valve Seat



» » Jenkins Brothers has recently announced No. 976 plug-seat valve that features a plug and seat ring made of stainless steel having a Brinell hardness in excess of 500. This valve is specially recommended for severe service such as continuous throttling for pressure reduction or free blow duty such as soot blowers, injectors, heating coils or any steam line where close regulation is required. Jenkins states that this plug and seat practically nullify wear and almost entirely eliminate danger of wire drawing and cutting.

Non-Slip Floor Finish

» » Designed to take the place of a floor wax where the use of this is dangerous or prohibitive is a new floor covering developed by the Warren Refining and Chemical Company, trade-named "Warcote".

The manufacturers state that the finish may be easily applied with a lamb's wool mop—is waterproof—gives a coverage of from 1500 to 3000 square feet, dries within a few minutes, and can be easily removed when necessary.

"Warcote" is said to have passed safety tests made by an insurance company and can contribute to decreasing injuries and deaths from simple accidents caused by slipping.

Ruggedwear Resurfacer

» » A new product, Ruggedwear Resurfacer, which should be of interest to the maintenance department of hospitals in which there are concrete floors, is offered by the Flexrock Company, 800 North Delaware Avenue, Philadelphia. It is used for resurfacing rough, worn or broken concrete floors. The claim is made that it is easily applied, dries in thirty hours and leaves a smooth but tough surface.

Flameproofing Simplified

» » The research laboratories of the Laboratory Equipment Company, New York City, have developed a new process of flameproofing, using a material called Ignex. The product is a clear liquid which can be applied without the use of any special equipment. It is not harmful to the most delicate fabric, the makers claim.

Ignex may be either sprayed or used as a dip. It does not "powder off" and is invisible even on black materials. Materials treated with the new liquid have been tested by the New York City Fire Department and by several commercial laboratories.

New Soap Dispenser

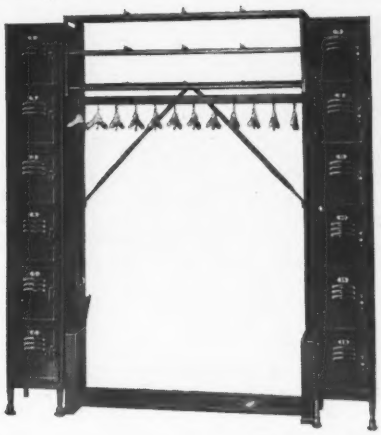
» » Developed recently by the Bobrick Dispenser Company is a heavy duty soap dispenser which dispenses a heavy, creamy lather instead of the usual liquid soap. The unit, trade-named Lathurn, pumps out a measured amount of lather composed of ninety per cent air, nine per cent water and one per cent soap. The lather is dispensed on an inward stroke and on the release any soap left in the spout is pumped back into the valve.

The soap spout is above the level of the liquid, the valve pumping the soap from the bottom of the supply tube. Sediment or dirt in the soap sinks to the bottom of the glass globe so that clogging of the valve is impossible.

The dispenser is of one piece construction. The soap supply is always visible, yet the glass globe is protected by the metal case. The glass globe is removable for draining or cleaning.

Valve and springs are of stainless steel, and Verdigris, the blue-green substance which forms on brass, is eliminated because stainless steel is not affected by soap or water.

Lock Box and Wardrobe Unit



» » Vogel-Peterson Company has announced a new combination wardrobe and locker unit that occupies only six square feet and accommodates twelve coats, twelve hats, eight umbrellas, shelf for rubbers and overshoes and twelve locker compartments.

The unit, being assembled of standard Peterson sections, is extremely flexible as to size. The wardrobe sections are available in any length, as they come by the foot and accommodate three persons per running foot. The locker sections, six compartments high, can also be added at will "by the foot", six compartments to the foot. The firm claims many unique patented features on this new wardrobe, including proper and fixed spacing of coat hangers; embossed and perforated ventilated steel hat shelves, individually divided and spaced; individual umbrella compartments with drip pans and overshoe shelf that keeps overshoes or galoshes in order.

"Cavalite" Hospital Sheeting

» » A new type of hospital sheeting, made from "Cavalite" rubber-coated silk, has recently been developed in the laboratories of the duPont Company.

Light weight and of smooth texture, it has been designed to fit snugly to the mattress.

A series of tests, reproducing conditions of rigorous hospital usage, was arranged to gauge the properties of the material. These included baking for thirty-five days in a Gear oven, a twenty-four hour period in which five sterilization preparations were applied, a four-hour exposure to steam, twenty-four hours of alcohol immersion, and twenty-four hours of ether, perspiration and urine testing. The firm states the sheeting showed no change throughout these tests.

HOSPITAL MANAGEMENT

INDEX to VOLUME 44

July to December, 1937

A

Accidents ..... September 8
Account Collection—R. W. Nelson ..... July 17
Adequate Health Program for Nursing—Florence R. Gilpin, ... August 45
Adjustment of the Affiliating Student in the Teaching Program—Alma Gault, R.N. ..... October 49
Administration of Occupational Therapy, The—D. D. Campbell, M.D. ..... November 24
Admission Officer, The—Rowland Dearing ..... July 24
Affiliating Student, Adjustment of—Alma Gault, R. N. ..... October 49
Air Conditioning—Editorial ..... December 13
American College of Hospital Administrators—Convention at Atlantic City ..... October 24
American College of Surgeons—Clinical Congress at Chicago ..... November 26
American Hospital Association—Convention at Atlantic City ..... October 24
American Protestant Hospital Association—Convention at Atlantic City ..... October 24
Anesthetists' Note Book ..... January 51
February 50, March 55, July 53
April, Rebecca—Case Work Service to the Aged .... July 18
Association of Record Librarians of North America—Conference at Chicago ..... November 54
Atlanta Cancer Clinic—T. C. Davison, M. D. ... October 22
Atlantic City in September ..... October 8

B

Baby Shows ..... September 8
Bartlett, Harriett M.—Professional Service of the Medical Social Worker ..... September 22
Basic Administrative and Functional Duties of the X-ray Department—Maximilian John Hubeny, M. D. ..... October 57
Beattie, Barbara A.—Nursing Service in the Small Hospital ..... September 44
Belknap, E. M.—Smudgy Walls, Grimy Ceilings, Dirty Floors ..... October 59
Beverages, Summer—Margaret Rosenmeier ..... August 37
Board of Directors ..... August 10
Borland, Mrs. Chauncey B.—Teaching Program in an Outpatient Department ..... July 48
Brown, Burton A., M. D. — Pharmacy Standards ..... September 21
Budgeting Our Time—Georgia A. Simmons .. September 59
Buying Melons ..... September 34

C

Campbell, D.D., M.D.—Administration of Occupational Therapy ..... November 24
Campbell, D.D., M.D.—Physical Exercise Therapy in Mental Hospitals ..... August 24
Cancer Clinic, Atlanta—T. C. Davison, M.D. ... October 22
Care of Resilient Floors—Clark Samuel ..... August 59
Case Work Service to the Aged—Rebecca April .... July 18
Casteen, Marie L.—Salads on Parade ..... July 32
Central Supply System—C. J. Cummings ..... July 25
Chemistry, Considerations on Instructions in—Bessie B. Colomb, R.N. ..... December 44
Chance Remarks ..... October 8
Christmas in the Hospital—T. R. Ponton, M.D.. December 14
Classification of Tumors — Horace B. Davidson, M. D. ..... October 54
Cleaning Terrazzo Floors ..... December 56
Clinical Charting, Interesting Student Nurses in—Ellen Pope, R.N. ..... November 46
Christmas Recipes—Margaret Rosenmeier .... December 34
Closed Staff ..... October 8
Collecting Accounts—R. W. Nelson ..... July 17
Colomb, Bessie B., R.N.—Considerations on Instruction in Chemistry ..... December 44
Communicable Disease—Editorial ..... November 12
Completion Test for Diabetics ..... July 40
Controlling the Flow of Oxygen ..... December 8
Criticism of the Hospital—Editorial ..... December 12
Cost of Shorter Hours—Editorial ..... October 14
Cummings, C. J.—Central Supply System ..... July 25
Considerations on Instruction in Chemistry—Bessie B. Colomb, R.N. ..... December 44
Cyclopropane—Ben Morgan, M. D. ..... December 52

D

Davidson, Horace B., M. D. — Classification of Tumors ..... October 54
Davison, T. C., M.D.—Atlanta Cancer Clinic .. October 22
Dearing, Rowland—The Admission Officer ..... July 24
Dietary Department, Organization of—Lute Troutt . July 34
Dietitian, Professional Service Standards of the—Zelia Kester ..... November 35
Differentiation Between Major and Minor Surgery—T. R. Ponton, M.D. ..... December 49
Do Employees Realize the Amount of their Compensations? ..... November 8

E

Education of Hospital Executives—Editorial ..... July 12
Elixir of Life ..... August 10
Emergency Service—Editorial ..... November 12
Employes, Hospital, and the Workmen's Compensation Act—I. H. Rubenstein ..... December 21
Examination before Anesthesia ..... July 54

F

Fever Therapy by Diathermy, What a Nurse Should Know About—Eunice M. Roth, R.N. ..... September 46
Fifth Annual Institute for Hospital Administrators—Neal Wood, M.D. ..... November 28
Fire Protection in Hospitals—E. Ray Gram .. December 22
Floors, Care of Resilient—Clark Samuel ..... August 59
Food Service, Some Problems in — Florence M. Stacey ..... August 35
Functional Requirements in the Planning of the Medical Records Room—William H. Walsh, M.D., and Percy W. Swern ..... November 53
Financial Demands of the New Curriculum on the

School of Nursing—Mrs. Joyce Knudtson Kuhn, R. N. ..... December 41

G

Gault, Alma — Adjustment of the Affiliating Student ..... October 49
Gilpin, Florence R.—An Adequate Health Program for Nursing ..... August 45
Gorgas, Nellie G.—Organization and Management of a Medical Records Department ..... September 52
Government's Interest in Our Sleep—N. E. Mattison, M. D. ..... December 55
Governing Body, The Responsibilities of the—T. R. Ponton, M. D. ..... November 14
Gram, E. Ray—Fire Protection in Hospitals .. December 22
Grapes, Some Notes on ..... November 38

H

Halloween Trays—Margaret Rosenmeier ..... October 36
Have a Heart ..... December 8
Have You a Hobby? ..... August 10
Health Program for Nursing, An Adequate—Florence R. Gilpin ..... August 45
Heathcote, F.—Some Laundry Problems ..... November 59
Henderson, Perlie deF.—Relationship of the Record Department to the Hospital ..... July 55
Hillkowitz, Philip, M. D.—Laboratory Service in the Small Hospital ..... July 22
Hospital and its Medical Staff, The—T. R. Ponton, M. D. ..... September 14
Hospital and the Indigent Emergency, The—Editorial ..... August 14
Hospital Employes and the Workmen's Compensation Act—I. H. Rubenstein ..... December 21
Hospital from the Patient's Angle, The ..... September 8
Hospital Pharmacy—Editorial ..... December 13
Hubeny, Maximilian John, M.D.—Basic Administrative and Functional Duties of the X-ray Department ..... October 57

I

Impetigo Again ..... December 8
Indigent Emergency, The Hospital and the — Editorial ..... August 14
Indigent in Voluntary Hospitals, The—Editorial. October 14
Ingratitude—Editorial ..... September 13
Installation of the Revised Curriculum for Schools of Nursing—Dora Mathis, R. N. ..... July 45
Interest in the Hospital, The Surgeon's—E. Payne Palmer, M. D., F.A.C.S. ..... November 22
Interesting Student Nurses in Clinical Charting—Ellen Pope, R. N. ..... November 46

K

Kester, Zelia—Professional Service Standards from the Standpoint of the Dietitian ..... November 35
Korngold, Janet Fenimore—Obstetrical Routine October 45
Kuhn, Mrs. Joyce Knudtson, R. N.—Financial Demands of the New Curriculum on the School of Nursing ..... December 41

L

Labor Situation, The—Editorial ..... July 12
Laboratory Requirements in the Hospital—Sidney J. S. Pierce, M. D. ..... November 57
Laboratory Service in the Small Hospital — Philip Hillkowitz, M. D. ..... July 22
Laundry Problems—F. Heathcote ..... November 59

M

Maintain the Standard of Service ..... September 8
Maintenance—A. H. Scheidt ..... July 59
Major and Minor Surgery, Differentiation Between —T. R. Ponton, M. D. ..... December 49
Maternal Mortality—Editorial ..... November 13
Mathis, Dora, R. N.—Installation of the Revised Curriculum for Schools of Nursing ..... July 45
Mathis, Dora, R. N.—Quadrennial International Congress of Nurses ..... September 43
Mattison, N. E., M.D.—The Government's Interest in Our Sleep ..... December 55
Medical Records Room, Functional Requirements in the Planning of—William H. Walsh, M. D. and Percy W. Swern ..... November 53
Medical Social Worker, Professional Service of the—Harriett M. Bartlett ..... September 22
Medical Staff ..... October 8
Medico-legal Value of Hospital Records—Caroline Raymond ..... August 52
Menus for the Holiday Season—Margaret Rosenmeier ..... December 33
Menu Ideas for the Staff — Margaret Rosenmeier ..... September 32
Midsummer Beverages—Margaret Rosenmeier .. August 37
Minor and Major Surgery, Differentiation Between—T. R. Ponton, M. D. ..... December 49
Morgan, Ben, M. D.—Scientific Anesthesia ..... August 57
Morgan, Ben, M. D.—Cyclopropane ..... December 52

N

Nelson, R. W.—Account Collection ..... July 17
New Curriculum, Financial Demands of, On the School of Nursing — Mrs. Joyce K. Kuhn, R. N. ..... December 41
New Intern—Editorial ..... September 12
Noise Elimination—Editorial ..... August 15
Noise Elimination in Hospitals—Jule Robert Von Sternberg ..... August 22
Nursing, Quality—Alice Rockwood, R. N. ..November 51
Nursing Service in the Small Hospital—Barbara A. Beattie ..... September 44
Nursing School, Financial Demands of the New Curriculum on—Mrs. Joyce K. Kuhn, R. N. .... December 41

O

Obstetrical Routine—Janet Fenimore Korngold October 45
Occupational Therapy, The Administration of—D. D. Campbell, M. D. ..... November 24
Oranges ..... September 36
Organization and Management of a Medical Records Department—Nellie G. Gorgas ..... September 52
Organization of a Dietary Department — Lute Troutt ..... July 34
Origin and Growth of the Women's Auxiliary—O. J. Sandaas ..... August 19
Outpatient Department, Teaching Program in an—Mrs. Chauncey B. Borland and Irene Stolp ..... July 48

P

Palmer, E. Payne, M. D., F.A.C.S.—The Surgeon's Interest in the Hospital ..... November 22
Pears for Menu Variety ..... August 36
Perfect Medical Records Committee ..... August 10
Personnel Management in the Hospital—Frank J. Walter ..... December 18
Pharmacy Hospital—Editorial ..... December 13
Pharmacy Standards — Burton A. Brown, M. D. ..... September 20
Physical Exercise Therapy in Mental Hospitals—D. D. Campbell, M. D. ..... August 24
Pierce Sidney J. S., M. D.—Laboratory Requirements in the Hospital ..... November 57
Policy and Program for a Voluntary Hospital—Clinton F. Smith ..... August 20
Ponton, T. R., M. D.—Venereal Disease in the United States ..... July 15
Ponton, T. R., M. D.—The Hospital and its Medical Staff ..... September 14
Ponton, T. R., M. D.—Christmas in the Hospital ..... December 14

Ponton, T. R., M. D.—Principles of Staff Organization ..... October 16
Ponton, T. R., M. D.—Responsibilities of the Governing Body ..... November 14
Ponton, T. R., M. D.—Differentiation Between Major and Minor Surgery ..... December 49
Pope, Ellen, R. N.—Interesting Student Nurses in Clinical Charting ..... November 46
Principles of Staff Organization—T. R. Ponton, M. D. ..... October 16
Professional Service of the Medical Social Worker—Harriett M. Bartlett ..... September 22
Professional Service Standards from the Standpoint of the Dietitian—Zelia Kester ..... November 35
Publicity—Editorial ..... October 15
Purchasing, Scientific—Herman Zaagman ..... July 21

Q

Quadrennial International Congress of Nurses—Dora Mathis, R. N. ..... September 43
Quality Nursing—Alice Rockwood, R. N. ..November 51

R

Radiation Therapy, Trend in—Francis Carter Wood ..... September 57
Raymond, Caroline—Medico-legal Value of Records ..... August 52
Recipes ..... August 37
September 32, October 35, November 36
Record Librarians of North America, Association ..... November 54
Relationship of the Record Department to the Hospital from Viewpoint of Record Librarian—Perlie deF. Henderson, R.R.L. ..... July 55
Requirements of the Laboratory in the Hospital—Sidney J. S. Pierce, M. D. ..... November 57
Responsibilities of the Governing Body, The—T. R. Ponton, M. D. ..... November 14
Revised Curriculum for Schools of Nursing, Installation of—Dora Mathis, R. N. ..... July 45
Rockwood, Alice, R. N.—Quality Nursing ....November 51
Rosenmeier, Margaret—Menu Ideas for the Staff ..... September 32
Rosenmeier, Margaret—Christmas Recipes ..December 34
Rosenmeier, Margaret—The Soft Diet ..... October 35
Rosenmeier, Margaret—Special Menus for the Holiday Season ..... December 33
Rosenmeier, Margaret—Halloween Trays .....October 37
Rosenmeier, Margaret—Summer Beverages .....August 37
Rosenmeier, Margaret—Turkey, What to Serve with ..... November 36
Rubenstein, I. H.—Hospital Employes and the Workmen's Compensation Act ..... December 21

S

Samuel, Clark—Care of Resilient Floors .....August 59
Sandaas, O. J.—Origin and Growth of the Women's Auxiliary ..... August 19
Scheidt, A. H.—Maintenance ..... July 59
Scientific Anesthesia—Ben Morgan, M. D. .....August 57
Scientific Purchasing—Herman Zaagman ..... July 21
Shorter Hours, Cost of—Editorial ..... October 14
Simmons, Georgia A.—Budgeting our Time .September 59
Sleep, The Government's Interest in Our—N. E. Mattison, M. D. ..... December 55
Small Hospital, Laboratory Service in the—Philip Hillkowitz, M. D. ..... July 22
Small Hospital, Nursing Service in the—Barbara A. Beattie ..... September 44
Smudgy Walls—Grimy Ceilings—Dirty Floors—E. M. Belknap ..... October 59
Soft Diet, The—Margaret Rosenmeier ..... October 35
Some Problems in Food Service—Florence M. Stacey ..... August 35
Speigel, Mrs. Arthur—Usefulness of the Women's Board ..... September 25
Stacey, Florence M.—Some Problems in Food Service ..... August 35
Staff Organization, Principles of—T. R. Ponton, M. D. ..... October 16
Standards In Selection of Fowl ..... September 36
Sterilization, Surgical—Weeden B. Underwood ..August 16
September 16, October 18, November 18
Stolp, Irene—Teaching Program in an Outpatient Department ..... July 48
Stop the Noise ..... November 8
Student Government ..... November 8
Surgeon's Interest in the Hospital, The—E. Payne Palmer, M.D., F.A.C.S. ..... November 22
Surgical Sterilization—Weeden B. Underwood ..August 16
September 16, October 18, November 18
Swern, Percy W.—Functional Requirements in the Planning of the Medical Records Room ...November 53

T

Taylor, Effie, J., Recognition for ..... November 45
Teaching Program in an Outpatient Department—Mrs. Chauncey B. Borland and Irene Stolp ....July 48
Terrazzo Floors, Cleaning ..... December 56
Travel and Disease Incidence—Editorial ..... July 13
Trend in Radiation Therapy, The—Francis Carter Wood, M. D. ..... September 57
Troutt, Lute—Organization of a Dietary Department ..... July 34
Turkey, What to Serve with—Margaret Rosenmeier ..... November 36

U

Underwood, Weeden B.—Surgical Sterilization ..August 16
September 16, October 18, November 18
Usefulness of the Women's Board—Mrs. Arthur Speigel ..... September 25

V

Venereal Disease in the United States—T. R. Ponton, M. D. ..... July 15
Vitamin C and Tuberculosis ..... September 35
Vitamin D Milk ..... October 41
Voluntary Hospital, Policy and Program for a—Clinton F. Smith ..... August 20
Voluntary Hospitals, The Indigent in—Editorial. October 14
Von Sternberg, Jule Robert—Noise Elimination in the Hospitals ..... August 22

W

Walsh, William H., M. D.—Functional Requirements in the Planning of the Medical Records Room ..... November 53
Walter, Frank J.—Personnel Management in the Hospital ..... December 18
What a Nurse Should Know about Fever Therapy by Diathermy—Eunice Ann Roth, R. N. .....September 46
Women's Auxiliary, Origin and Growth of—O. J. Sandaas ..... August 19
Wood, Francis Carter, M. D.—The Trend in Radiation Therapy ..... September 57
Workmen's Compensation Act, Hospital Employes and the—I. H. Rubenstein ..... December 21

X

X-ray Department, Administrative and Functional Duties of—Maximilian John Hubeny, M. D....October 57

Z

Zaagman, Herman—Scientific Purchasing ..... July 21

IN 1867

Joseph Lister Became The Symbol of the Antiseptic Principle

The Mallinckrodt Label Became the Symbol of Fine Hospital Chemicals

In 1867 Joseph Lister staggered the scientific world with his Antiseptic Principle. That same year Mallinckrodt Chemicals came into existence . . . to offer a new high standard of excellence for the hospital pharmacy and laboratory.

During 70 years of medical and scientific progress Mallinckrodt has faithfully served the great hospitals of the country. Strict surveillance of production procedures and rigorous assays of finished products have earned the acclaim of pharmacists and physicians. From time-honored stand-bys to recently substantiated innovations, Mallinckrodt Chemicals are outstanding for their purity, uniformity, and therapeutic potency.

A partial list of Mallinckrodt Hospital Chemicals:

Acid Boric U.S.P. . . . Acid Carbolic U.S.P. . . . Caffeine Citrated . . . Hydrogen Peroxide U.S.P. . . . Acetphenetidin U.S.P. . . . Zinc Oxide . . . Lactic Acid U.S.P. . . . Ichthymall . . . Zinc Stearate . . . and a long line of Alkaloids, Anesthetics, Arsenicals, Bismuth Salts, Iron Salts, Citrates, Iodides, Mercury Salts, Silver Salts, and Analytical Reagents.

Send for list of Mallinckrodt Hospital Chemicals.

ST. LOUIS
CHICAGO
PHILADELPHIA

Mallinckrodt
CHEMICAL WORKS

NEW YORK
MONTREAL
TORONTO

FINE PRESCRIPTION CHEMICALS FOR 70 YEARS

This trade mark identifies all hospital products manufactured by The Seamless Rubber Co. Look for it—it is a mark of quality.

Stopperless

COMBINATION WATER BOTTLE & ICE CAP

Available with smooth surface also

SOFT RUBBER CLOSURE—can be placed at any part of the patient's body without discomfort.

STOPPERLESS—no stopper to lose or become loose while in use.

LARGE OPENING to admit ice cubes or prevent spouting steam when being filled with hot water.

FLUTED SIDES increase radiation. Tested and approved by Good Housekeeping Institute.

An economical double-duty item. Order today from your Supply House. Specify Seamless Stopperless Hot Water Bottle & Ice Cap.

In addition to the Seamless Stopperless Bottle, your Hospital Supply House maintains complete stocks of a wide variety of other Seamless rubber products for hospital use.

seamless

THE SEAMLESS RUBBER CO., INC., NEW HAVEN, CONN.